IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
AT CHARLESTON

THE CITY OF HUNTINGTON,	:	Civil Action
Plaintiff,	:	No. 3:17-cv-01362
v.	:	
AMERISOURCEBERGEN DRUG CORPORATION, et al.,	:	
Defendants.	:	
CABELL COUNTY COMMISSION,	:	Civil Action
Plaintiff,	:	No. 3:17-cv-01665
v.	:	
AMERISOURCEBERGEN DRUG CORPORATION, et al.,	:	
Defendants.	:	

BENCH TRIAL - VOLUME 38
BEFORE THE HONORABLE DAVID A. FABER, SENIOR STATUS JUDGE
UNITED STATES DISTRICT COURT
IN CHARLESTON, WEST VIRGINIA

JULY 12, 2021

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PROCEEDINGS had before The Honorable David A. Faber, Senior Status Judge, United States District Court, Southern District of West Virginia, in Charleston, West Virginia, on July 12, 2021, at 9:00 a.m., as follows:

THE COURT: Good morning.

SIMULTANEOUS SPEAKERS: Good morning, Your Honor.

THE COURT: You can call your next witness.

MR. HESTER: The defense calls Dr. Robert Rufus to the stand.

COURTROOM DEPUTY CLERK: Sir, would you please state your name?

THE WITNESS: Robert James Rufus.

COURTROOM DEPUTY CLERK: Thank you. Could you raise your right hand?

DR. ROBERT J. RUFUS, DEFENSE WITNESS, SWORN

COURTROOM DEPUTY CLERK: Thank you. Please take a seat.

THE WITNESS: Your Honor.

THE COURT: Good morning, sir.

DIRECT EXAMINATION

BY MR. HESTER:

Q. Good morning, Dr. Rufus.

A. Good morning.

Q. Could you please introduce yourself to the Court?

A. My name is Robert James Rufus.

Q. And, Dr. Rufus, what is your profession?

A. I'm a certified public accountant.

Q. And did you establish your own accounting firm at one point?

A. I did. I started Rufus & Rufus Accounting Corporation in 1985.

Q. And where was that based, Dr. Rufus?

A. Huntington, West Virginia.

Q. And how many years did your firm operate in Huntington?

A. Operated as Rufus & Rufus until 2017. And it morphed into Rufus & Miller, which operated from 2017 through 2019.

Q. And did you live in Huntington during those years?

A. I did. I lived in Huntington for 30 years.

Q. And where did you grow up before you lived in Huntington, Dr. Rufus?

A. I grew up outside of Beckley, West Virginia, a small town called Shady Spring.

Q. Where did you go to college?

A. I did my undergrad work at Concord College, now Concord University.

Q. Where is that based?

A. It's in Athens, West Virginia.

Q. And what did you study at Concord?

A. I have a degree in Business Administration with a concentration in Accounting. I graduated with honors in

1978.

Q. And do you have any other degrees?

A. Yes. I have a Masters in Business Administration from Marshall University with concentration in Accounting and I received that in 1981. I also have a Doctorate in Business Administration with concentration in Accounting, which I earned from Nova Southeastern University.

Q. And when did you receive your Doctorate in Accounting?

A. In 2007.

Q. Are you a certified public accountant?

A. I am.

Q. And what is public accounting, just at a high level?

A. Public accounting is the offering of accounting services to the public. I mean, that's an awkward definition, but that's, in essence, what it is.

Q. And when did you become a certified public accountant, Dr. Rufus?

A. I became a CPA in 1981.

Q. And are you still practicing as a CPA?

A. I am.

Q. Do you have any other certifications aside from your certification as a CPA?

A. Yes. I'm also certified in financial forensics and I was also certified as a valuation analyst.

Q. And what do those certification qualify you to do?

A. Well, it's not so much what they qualify, but what they signify. Those certifications signify a high level of achievement and competence in the accounting profession.

Q. Are you a member of any professional societies?

A. I'm a member of the West Virginia Society of CPAs. I'm also a member of the American Institute of Certified Public Accountants.

Q. So, we talked about your becoming a CPA in 1981. After you became a CPA, what did you do next?

A. Well, actually, after I graduated, I went to work for the Internal Revenue Service and I worked as an IRS agent in Huntington for roughly five years.

Q. And what were you doing as an IRS agent?

A. Well, as an IRS agent, I did the examination of personal, corporate and business tax returns.

Q. And then you mentioned that you started your own firm. That was in 1985?

A. Yes. When I left the Internal Revenue Service, I formed Rufus & Rufus Accounting Corporation.

Q. And roughly, at a high generality again, what services did your firm provide?

A. Well, the nature of our services evolved. We started out as a public accounting firm and public accounting firms offer a variety of services. They offer accounting services, financial statement and preparation, tax return

preparation, IRS representation, audit work, management advisory services.

Our firm then evolved into a higher level of service offering where we went into forensic accounting, support litigation, a lot of business valuations, arbitration-type work.

Q. And what type of clients did you work with at your firm?

A. Well, just a full array of firms. We worked with professionals, physicians, attorneys, dentists, engineers, insurance companies, insurance agents, contractors, just about everything you can imagine. Auto dealers.

Q. You mentioned your evolution into forensic accounting. Could you describe what forensic accounting is?

A. Forensic accounting, as the name implies, is the application of accounting concepts and principles in a legal setting. But -- I mean, but normally forensic accounting is fully defined by what we do and, again, it's an array of anything related to legal matters.

Q. And is that an area that you focused on for some period of years, forensic accounting?

A. It is. Forensic accounting and tax work.

Q. And what type of work are you doing today?

A. Well, I'm doing -- you mean as I sit here?

Q. No. A little more broadly than just sitting here.

A. Okay. I do tax work. I do some management consulting. And I do some mergers and acquisition work.

Q. So, Dr. Rufus, I'd like to turn to another part of your professional life. Have you also been a teacher and an academic?

A. I have. I started my teaching career when I was with the IRS. My first teaching assignment was with the West Virginia College of Graduate Studies, which is now part of Marshall University. I think that was in 1983 or '82.

I taught graduate finance from -- during that period, 1982, I think, up through -- or 1982 through 1992. I was an adjunct professor with Marshall University, intermittently teaching accounting and tax as needed.

When I left the Internal Revenue Service in 1985 I went to work full time, really, for Ohio University at the same time I was building our firm. As an instructor I taught economics both in macro and micro. I taught finance. And I taught accounting.

In 2007, I think, I took a teaching position with Charleston University, where I taught in their executive masters and business administration. I taught the Capstone program.

In 2008, I was the lead instructor and program developer for the masters in forensic accounting, which was offered through the University of Charleston, and I taught

and ran that program from 2008, I think, through 2018.

Q. What was your -- what was your role at the University of Charleston as the program coordinator and lead instructor in forensic accounting?

A. Well, actually, it was a double role. The program was developed through an entity called the Forensic Institute, which was owned by myself, my associate, Dr. Laura Miller, Judge Dwane Tinsley and Stacey Halloran. And we developed a forensic program and contracted to -- with the University of Charleston to implement the program.

We were responsible for program updates. We were responsible for case materials, case assignments, case overview. And then, we carried that to the classroom where we -- where we employed the program with students.

Q. Did you also publish any academic papers or books, Dr. Rufus?

A. Yes. Through -- through the years I've published on forensic accounting primarily with a focus on some of the things that we emphasized in the program, critical thinking, research, writing, data, data analysis.

I also published a textbook called Forensic Accounting. That was published with Pearson, which is the largest academic publisher in the world.

Q. What year was your textbook published?

A. I think it was 2014.

Q. And is your textbook used around the country by a number of colleges?

A. The last conversation I had with Pearson, which was a couple of years ago, it was used in more than a hundred colleges and universities in the country.

Q. So, let me turn now to another part of your professional life, Dr. Rufus. Do you periodically serve as an expert witness in litigation and arbitration?

A. I do.

Q. And how does your expertise as a forensic accountant come into play as an expert witness?

A. Well, it comes into play from start to finish. What forensic accountants do is really driven by the nature of the engagement. We employ critical thinking. We understand data. At the end of the day, our objective is to gather sufficient reliable data, put it in a form where we can give a legally sufficient opinion.

Q. When you're serving as an expert, have you generally been retained by plaintiffs, or defendants, or has it been a mix?

A. It's a mix.

Q. And so, in preparing for your work in this case, did you work with a team to develop your opinions?

A. I did. I worked with two teams. I worked with my former associate, Dr. Laura Miller. Dr. Miller assisted

with writing and editing and proofing of the narrative work.

I also worked with a group from Alvarez & Marsal. They were generally responsible for data collection. They also did proofing of worksheets and also helped me navigate various websites in order to collect data.

Q. How long did you and your team work on this project before you submitted your report in August of last year?

A. How long? I -- I don't know. I think we were engaged in February and I think our -- but it was roughly 500 hours worth of work.

Q. And after you submitted your expert report, have you continued to engage in this project and put time into it after you submitted your expert report?

A. Yes, that's correct. I've continued to inform myself about the project. I've also reviewed supplemental deposition testimony and amendments to other expert reports.

Q. So, let's just summarize bits. We've talked about your involvement in teaching and academic research, your experience as an expert witness and, of course, your deep background in accounting matters, including forensic accounting. Throughout those different areas, what's been the focus of your work?

A. Well, throughout those different areas, the focus of my work has been in forensic accounting.

Q. And how long have you been focused on this area of

forensic accounting?

A. Well, again, I left the Internal Revenue Service in 1985 and I carried with me those skills and that training. So, I would say for at least 35 years.

MR. HESTER: Your Honor, I now tender the witness as an expert in public and forensic accounting.

THE COURT: Any objection?

MR. MAJESTRO: Your Honor, we don't have any objection generally. Some of the matters in Mr. Rufus's report we believe stray beyond that expertise and -- but on the general level, we have no objection to the expertise. I'll make a -- if he offers that testimony, I'll object at the time.

THE COURT: All right. The Court finds Dr. Rufus to be a qualified expert in the fields of public and forensic accounting.

BY MR. HESTER:

Q. So, Dr. Rufus, before we get into your opinions in this case, I'd like to identify several topics on which you're not offering opinions, just to be clear on the scope of what you're discussing with the Court today.

Are you offering any opinions on causation or fault?

A. I am not.

Q. Are you offering any opinions on whether any of the abatement programs that are proposed by Dr. Alexander are

necessary?

A. I am not.

Q. Are you offering any opinions on the medical judgments that underlie Dr. Alexander's proposed abatement plan?

A. I am not.

Q. Are you offering any opinions on capacity or effectiveness of existing programs in Huntington and Cabell County?

A. No.

Q. Are you offering any opinions on the conduct of distributors?

A. No.

Q. And are you offering any opinions related to the volume of prescription opioids distributed into West Virginia or, specifically, into Huntington and Cabell County?

A. No.

Q. All right. So now, Dr. Rufus, let's turn to your opinions.

What were you asked to do in this case at a high level?

A. At a high level, I was engaged to do two things. One, I was engaged to identify and quantify investments made by the plaintiffs and programs that were designed to help manage the opioid crisis. And the second component at a high level would be to consider the economic drivers of the expert reports of Dr. Alexander and George Barrett.

Q. So, let's talk about the first part of your work. Are you able to offer opinions on the expenditures that Huntington or Cabell County have made for programs that they have identified as addressing the opioid crisis?

A. Yes.

Q. And how did you go about determining the programs that are funded or administered by the City of Huntington or Cabell County that they've identified as addressing the opioid crisis? How did you do that work?

A. Well, actually, it was a process. It was really a four-step process, if you will. The first thing I did was identify or list out of all the programs that were identified by the plaintiffs either in response to interrogatories or identified in the public domain. And then, I attempted to reduce that -- that population or that list and I was able to do that by the publication City of Solutions, which identified each of those programs in great detail and also helped me identify which programs were managed, if you will, or funded by the City or the County.

And then, after that population was reduced, those programs were identified, the third step would be to gather as much financial information as was available. And that included primarily grant applications and budgets.

And then having identified those programs and the financials, I wanted to confirm my understanding of that and

I did that through the reading of various depositions, Mayor Williams or -- and, also, Dr. O'Connell, Chief Rader, Ms. Priddy, and things of that nature.

Q. And since you've compiled your report, have you reviewed additional materials to confirm your judgments about the programs that are either administered by or funded by the City or the County that relate to the opioid crisis?

A. Since I've issued my report?

Q. Yes.

A. Yes, I have.

Q. And what have you done to confirm some of the judgments you reached?

A. Well, again, it was the same process. I looked at revised reports. I looked at the budget of the City of Huntington. I've looked at information in the public domain regarding obligations related to those programs.

For example, Mayor Williams in his City of the State Address noted that the City was going to start funding the LEAD program and that the City was going to start funding the Compass program, which is one of the six programs that I identified. So, that's information I acquired subsequently.

Q. Did you also review trial testimony in this case to confirm some of your judgments about the program that are administered or funded by the City or the County?

A. Oh, yeah. Absolutely. Primarily, I think it would be

Dr. O'Connell's testimony that was very helpful in making sure I understood the framing of the programs and who managed the programs and how they were funded, as well as the trial testimony of Mayor Williams.

Q. So, let me ask you, Dr. Rufus, if you can look at a demonstrative here and we'll put this up on the board. Dr. --

A. Excuse me one second. Is it going to come up on the screen beside of me?

Q. Is that next to you, too?

A. Okay, here it is. Okay. I've got it.

Q. So, Dr. Rufus, first, at a very high level, what is this table that we've put up?

A. This is a table that I -- that I presented in my report that was issued and it is a summary table. And, again, you'll see it's noted as Table 2.13 and, reading left from right, it identifies what the program is and then I break down the various funding for the program.

Q. So, let me just set the table here a little bit. Does this table reflect your findings as to the programs that you concluded were the ones that the City or the County had identified as ones they administer or fund related to the opioid crisis?

A. Yes, it does.

Q. Okay. And then we'll talk about the cost data and the

numbers shortly, but let's first walk briefly through the programs. So, the first program that you have up on the list is the Law Enforcement Assisted Diversion Program. Do you see that?

A. I do.

Q. Is that also referred to as LEAD?

A. It is.

Q. And can you describe, just generally, what that is?

A. Well, as the -- as the name implies, it's a law enforcement diversion program. It's a pre-booking program where law enforcement attempts to move individuals into treatment instead of into the justice system. Those are individuals that generally are identified as having substance abuse and/or mental health issues.

Q. And what's your understanding of this next one, the Harm Reduction Program?

A. My understanding of Harm Reduction is it is not a prevention program. It is a strategy -- a battery of programs and the strategy is to reduce the harm associated with drug use.

Q. Now, is that Harm Reduction Program run by Cabell County or the City of Huntington?

A. It is not. It is run and managed by the Cabell County Health Department.

Q. So, why did you include that on your list here?

A. It was included on the list because the Health Department is in part funded by a special levy through Cabell County.

Q. So, the next one down is the Drug Court/WEAR. What's your understanding of what that is?

A. Well, the drug court is a special court that's supervised by the West Virginia Supreme Court. The WEAR program is Women Empowerment and Addiction Recovery, I think, and that was a grant program to support women in the drug court who had generally been involved in prostitution and, again, it was a program to move them to treatment and away from -- and away from criminal justice.

Q. The next one on the list is Turn Around. What does that refer to?

A. Turn Around was another grant program. The City of Huntington partnered with the West Virginia Regional Jail on that program and it provides counseling for non-felony inmates, again, to move them into -- into a better life, if you will.

Q. The next one down is the Quick Response Team. What's your understanding of what that relates to?

A. The Quick Response Team, as the name implies, it's the quick response to suspected overdose individuals. Within 72 hours or something the team goes out. They attempt to contact the individual and they attempt to link them to

treatment and away from drug abuse.

Q. And the last one on the list there is Compass. What does that refer to, to your understanding?

A. That's the Compassion Fatigue Program for First Responders in the City of Huntington.

Q. So, I notice that the Mayor's Office of Drug Control Policy isn't listed here. Why is that?

A. Because at the date of my report, it was my understanding that that program had been either shut down or discontinued.

Q. And have you identified any specific costs that have been allocated to the Mayor's Office of Drug Control Policy?

A. You mean after my report?

Q. Yes.

A. Yes. Subsequent to my report, I reviewed the budget of the City of Huntington for 2021-22 and there was an allocation or a budget item for the Mayor's Office of Drug Control Policy, which was roughly $100,000.00.

Q. So, the six programs that you've listed here that we've just gone through, plus the Mayor's Office of Drug Control Policy, are those the only programs that you have identified that are either funded or administered by the City or the County that specifically relate to opioid issues?

A. Yes, that's correct.

Q. And you also compiled the costs for these programs; is

that right?

A. That's correct.

Q. And how did you calculate those costs?

A. The costs were calculated in major part from the grant applications and budget data that I was provided with respect to each one of the programs.

Q. So, you have a part of this chart that shows City and County funds and there's a first column here for direct. What does that refer to?

A. Direct contribution would be out-of-pocket contribution or cash contribution.

Q. So, that would be a cash contribution or cash payment by the City or County?

A. Yes, that's correct.

Q. The next column shows in-kind contributions. What does that refer to?

A. Well, the programs, as you'll see, most of them request a matching by the City or County and that in-kind reflects the matching component and it's normally an allocation of personnel costs.

Q. So, just for the record, how much do you show in the direct funding by the City or the County?

A. For -- for all the programs, $5,162.00.

Q. And how much do you show for in-kind contributions by the City or the County?

A. For all the programs, it's $131,358.00.

Q. And these numbers, by the way, Dr. Rufus, all of the numbers on this chart are annual numbers; is that right?

A. Yes, that's correct.

Q. So, the total -- what do you show as the total funding by the City or the County for these programs?

A. $136,520.00.

Q. And then, if we wanted to add the number that you mentioned for the Mayor's Office of Drug Control Policy, what would that be, if you added that in?

A. Again, that's another hundred thousand dollars, so it would be $236,520.00.

Q. And so, now let's turn to these other columns. You've got a column here for external funds. What does that signify?

A. External funds reflects a third-party investment in the program and most of that is from grant funding.

Q. When you say third-party investment in the program, can you just explain what you mean by that?

A. Yeah. Third party would be the grantor. In other words, it might be SAMHSA, it might by the Bureau of Justice. It can be any third party other than -- other than the plaintiffs.

Q. So, this column for external funds reflects grant money or other -- other money coming from third parties to support

these programs that you have listed here; is that right?

A. That's correct.

Q. And what's the total that you show for the grant funding?

A. The total is $1,934,188.00.

Q. So, if we put together the total costs of these programs that you've identified here as being the only ones that are funded or administered by the City or the County related specifically to opioid issues, what's the total dollar amount of these programs?

A. Total dollar amount is $2,070,708.00 and, again, if you added in the Mayor's Office of Drug Control Policy, the hundred thousand dollars, it would be $2,170,708.00.

Q. Now, we talked about this point of grant money coming to the City or the County to support some of these programs. Are you aware of some changes that are coming with respect to the funding of some of these programs?

A. I am. I'm aware of that through various ways, but I'm aware that -- again, I mentioned the LEAD program and I think the mayor has testified that the City is going to be funding that. And so that would be -- that's roughly $43,000.00, is what I think he put in the budget.

And, again, when I say evidence I've looked at, I've looked at trial testimony and I've also looked at the City's new budget. And there was a budgeted provision for a

counselor for the LEAD program and, again, that's $43,000.

Also, I understand that the City is going to assume and take over the responsibility for the Compass program and I think in the budget it was $301,000.00.

I also understand that the funding for the Quick Response Team is dried up. And I think Ms. Priddy, who is the coordinator of that team, has testified that that budget is about $350,000.00 a year.

Q. So, let's just clarify that, what you've just said. So, you indicated that the LEAD program, which today shows grant funding of about $83,000.00; is that right?

A. That's correct. That's right.

Q. And your point was that the LEAD program would be budgeted in the City budget at $43,000 this coming year?

A. Well, not the program is not identified, but the individual who is going to be working in the program, which is the counselor, is going to be identified and the budgeted item for her or him was $43,000.00.

Q. And you mentioned the Compass program which shows grant funding of $338,000; is that right?

A. That's correct.

Q. And the City is going to be funding it at the level of what did you say, $301,000?

A. Yes, that's correct.

Q. And then, you had also mentioned the Quick Response

Team program, or QRT, and you had said that it would be funded at the level of $350,000; is that right?

A. That's correct.

Q. What was the grant level received for the Quick Response Team last year?

A. Well -- well, last year was an extended year, but the Quick Response Team was a three-year grant program. It was extended for another year and I think if you -- if you did the math differently, it would work out to about $350,000 a year.

Q. So, the three items that you mentioned that the City and the County are now budgeting that they previously received grant money for, they're slightly below the amounts that they were receiving in grant money; is that right?

A. Yes, that's correct.

Q. Do you also understand, Dr. Rufus, that for these three programs where the grant money may not be available, that there could be new grants coming that would support these programs as you look ahead?

A. Yes. Yes. That's certainly possible. I mean, grant funding is provided by policy makers and, as long as policy makers identify a problem then, normally, money is made available for the problem, but grant money is not guaranteed. That's a fact.

Q. The -- whatever the change between the grant money and

the funding from the City or the County, would you expect the total for these programs to stay in this range that you show here?

A. Yes, that's correct. I certainly wouldn't expect it to be more than -- more than $2 million dollars a year.

Q. Aside from the specific programs that we've just discussed, Dr. Rufus, have you seen any other evidence of added cost for the City or the County that they've occurred due to the opioid crisis?

A. Yes.

Q. And how did you evaluate that?

A. Well, I guess the first question would be how is it identified. One of the things I did is I took the budgets and the financial statements for each respective party, the City of Huntington and also Cabell County, and I did a time series analysis.

I went back to 2013, tracked it all the way up through the current budget, which would be ending 2022, and I was looking for ticks or upticks in expenses.

And for the City of Huntington, for example, I really focused on public safety to see if there was a swing in incremental costs, if you will. I looked at detailed data as it relates to the Police Department and the Fire Department. And I did not identify any upticks, which you would expect if you're seeing this blur into the City.

Oh, I'm sorry.

Q. Well, when you say you didn't identify any upticks, can you explain what you mean by that?

A. Well, any -- any incremental costs. In other words, the costs associated with the City and the budgetary process is really pretty smooth over the period. There's some growth and there's some changes, but as a rule, the allocation of the budget is very smooth.

I was able to confirm, or at least my understanding on the City budget with the testimony of Captain Underwood, I think that's his name, who is the administrator with the Huntington Police Department, where he testified that no additional funding had been requested by the Police Department as it relates to the opioid management and that they'd always come in under budget.

Q. So, let me set the table a little bit on what you did first. So, what was the period of years that you were looking at in terms of financial statements for the City and the County?

A. I went back all the way to 2013.

Q. Up to what time period?

A. For the County, I went to 2021. That was the last budget that was posted. For the City, I went and included their current budget, which was the 2021-2022.

Q. And was your objective -- what was your objective in

looking at those budgets over time? What were you trying to assess?

A. Well, actually, I was attempting to assess several things. One is to identify what the City does, what services are offered, how revenue is generated, what are the components of their budget. So, in other words, what services are offered, how much does it cost, and how is it funded.

And then, I took the next step to say the focus should be -- or at least for me -- in public safety. So, public safety includes the Police Department and Fire Department. So, I looked at the detail data for those two entities looking for incremental costs that I could identify to the opioid crisis.

Q. Did you see any large increases in costs as you looked at that period from 2013 up to 2020-2021?

A. I did not, at the City level, at any rate.

Q. And -- okay. So, first, let's focus on the city budget. You did not see during that period any meaningful changes in cost?

A. I did not, no.

Q. What about at the county level?

A. At the county level, I did see some changes which I thought were significant changes that might lend itself to the opioid crisis.

Q. And what was that?

A. Well, there were two changes. One was payments to the regional jail system, so -- which was erratic. It went from $3 million a year, to $4 million, to $5 million. And now, it's leveled back off to $3 million.

So, then I had to go back to say let me understand what is happening with the regional jail system. And in my report I put out a narrative as it relates to that, but there was certainly an uptick as it relates to payments to the regional jail system.

Q. And how much was the uptick roughly?

A. Well, again, it changed. It went from $3 million, to $4 million, to $5 million, back to $3 million. So, you know, the change could be $2 million bucks.

Q. And those are payments made by the County to the -- to the jail system, the Western Regional Jail?

A. Yes, that's correct.

Q. And aside from the jail, did you see any other meaningful changes in costs from this period from 2013 to 2020-21 for the County?

A. Yeah. In the county budget, I also noticed there was an increase in the sheriff's budget, roughly a half million bucks.

Q. Aside from those two points, did you see any other meaningful changes in costs for the county budget?

A. I did not.

Q. Dr. Rufus, have you also evaluated whether the City or the County -- oh, let me go back for a second before we do that.

You had mentioned the testimony of Captain Underwood. What was the significance of that to you?

A. The significance of that to me, I read the -- I read the deposition of Runyon, who was the city finance manager, I believe, and his testimony in his deposition was that the opioid crisis had an impact all the way through the financial system of the city and I was looking for that. I was searching for that.

But when I read Captain Underwood's deposition, what he said was, that's not true, that they had the money that they needed, they -- that they were active in securing grants. They had never asked for additional funding for opioid fights and that they had always come in under budget. But that's what I was looking at. I was looking for incremental costs that I could candidly tie to the opioid crisis.

Q. Did you also see deposition testimony from the mayor, Mayor Williams, that bore on these issues?

A. Yes. During his deposition and also his trial testimony was that the City of Huntington had not spent any money in fighting the opioid crisis, or at least not directly, that funds were available for alternative sources

grants. But moreover was that the City had no intentions of spending money for these programs.

Q. Dr. Rufus, have you evaluated whether the City or the County have excess revenues or unassigned funds?

A. Yeah. That's one of the things I did when I went through the City's financial statements, is a large component of their budget is unassigned fund bounds, and that fund bounds moved I think it was -- maybe in 2019 it was $6 million. The end of 2021 it was $15 million. And I think the projected for the 2022 budget is $17 million.

Q. What does it mean when you say something is -- has unassigned funds or you identified unassigned funds in the city budget?

A. The concept of unassigned funds is really -- is fully to fund by the Auditor's Office, but it includes unrestricted funds; in other words, money left over at the end of the period.

Q. So -- so are unassigned funds reflective of money that is left over after all the expenses are paid by the City for the year?

A. That's correct. It's available funding for whatever purpose the City and the Council decide.

Q. And could you say again what was the trajectory of the unassigned funds over the period you reviewed?

A. It increased every year. I mean, an odd observation I

made was during the period, the financial condition of the city actually improved. I think Mayor Williams testified that the health of the city was better now than it's been in 50 years.

But at any rate, the trend went from $6 million to $15 million and now it's projected to be $17 million, which is about 25 percent of the overall budget.

Q. Have the City or the County directed any of these excess funds, this leftover money, have they directed any of that to address opioid issues?

A. No. And, as I mentioned, Mayor Williams testified that he was not going to do that. Now, when you talk about excess funding, I didn't mention the County. From the county budget, it's indicated that there was $500,000 and I think the projected budget for 2021 is going to be $600,000.

Q. So, when you say $600,000, that means leftover money in the county budget that they're not spending?

A. That's correct.

Q. And have you seen any indication that the county is allocating that leftover money to any opioid issues?

A. No.

Q. All right. Let's shift gears from your discussion of the city and the county budgets and let's talk about Dr. Alexander's redress model.

Dr. Rufus, what did you consider, at a general level

again, when you were looking at Dr. Alexander's redress model in the ways that Mr. Barrett costed out that model?

A. Well, my approach is actually a little different. I started with the Barrett report and I read his summary as to say what was he engaged to do and what did he rely on. And then I went from the Barrett report to the Alexander report. But, I mean, in essence what I was doing when Barrett's -- his calculation indicated there was a $2.5 billion dollar number and my first question was, I need to break it down to make sure I understand what the drivers of that number are. So, again, I went from Barrett's report into Alexander's report.

Q. What do you mean when you say the drivers of those numbers?

A. In other words, what causes -- or what programs are being proposed and what drives the $2.5 billion dollar number. So, I was asking, you know, is it population? Is it cost? Is it something else? I mean, again, I was curious to know what was driving the number.

Q. So, let's put up a demonstrative. Dr. Rufus, did you prepare this demonstrative?

A. I did.

Q. And what does it reflect at a general level?

A. At a general level, reading left to right, it identifies the various programs that are in Dr. Alexander's

plan and it breaks it down by category and then subcategory. And then, it identifies the costs that have been assigned to those various plans by George Barrett. And then, on the far right would be the subtotal of those individual categories.

Q. So, let's -- let's just break this down just a little bit more. So, we have categories listed here, Category 1 for prevention with 1A through F underneath it. Category 2 for treatment, 2A through 2E. Category 3 for recovery, with 3A through 3E. And Category 4, addressing needs for special populations, 4A to 4E. What are those categories?

A. What are those categories?

Q. Are those the categories in Dr. Alexander's redress model?

A. Yes, that's correct.

Q. And then, what are the numbers here? Dr. Alexander didn't derive the numbers, did he, for the redress model?

A. He did not. As I said, this really is framed with -- from George Barrett's report and the numbers are driven or calculated by George Barrett based upon information he received from Dr. Alexander.

Q. So -- so, Dr. Rufus, is it fair to say you've put together here the categories from Dr. Alexander's redress model along with the numbers assigned by Dr. -- by Mr. Barrett?

A. Yes, that's correct.

Q. And then, we have -- over on this right-hand side, we have some numbers. What do those reflect?

A. Those reflect -- as I mentioned, those are the totals of those respective categories.

Q. So, for the record, what is the total cost that you show for Category 1, prevention?

A. $48,720,555.00.

Q. And what is the total cost for Category 2, treatment?

A. $2,050,815,634.00.

Q. And what's the total cost for Category 3, recovery?

A. $99,238,834.00.

Q. And what's the total cost for Category 4 addressing the needs for special populations?

A. $345,671,523.00.

Q. Now, are any of these numbers discounted for net present value?

A. No. This is all future value.

Q. And what's your understanding at a high level, Dr. Rufus, as to what's covered by Categories 2, 3 and 4?

A. Categories 2, 3 and 4, it's my understanding is that is the downstream costs or byproduct, if you will, of drug use.

Q. So, do Categories 2, 3, and 4 include money for treatment for people who are abusing drugs?

A. Yes, that's correct.

Q. And what do you mean by downstream costs?

A. Well, it's the consequence. It's the after fact. It's the byproduct. It's not a prevention. It's after someone, or someone's family, or family member, has been addicted to opioids.

Q. When you say the consequence, or the after effect, the byproduct, the byproduct of what?

A. Of drug use.

Q. And so, Categories 2, 3 and 4 would also include different kinds of treatment, such as people with HIV, or hepatitis, or OUD, correct?

A. Yes, that's correct. Yes, that's right.

Q. So, Dr. Rufus, I'm going to get you a calculator.

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes.

BY MR. HESTER:

Q. Dr. Rufus, can you -- can you tell us the percentage of Dr. Alexander's total abatement costs that are reflected in Categories 2, 3 and 4?

A. Well, that was a bad process. I've calculated this before and it's roughly 98 percent, but I will try it one more time, if you would like.

Q. Doctor Rufus, you could subtract -- you could -- you could do it the other way around, right? You could take the first category?

A. Thank you.

MR. MAJESTRO: The calculator failures continue.

THE WITNESS: Yes, that's correct.

Well, yeah. It's up in the air on me. So, let me do it one other way.

BY MR. HESTER:

Q. So we don't take the time of the Court, Dr. Rufus, how -- just explain to me how you would calculate that.

A. How I could calculate the percentage? I would -- I would do it one of two ways. I could take the $48,720,555 and divide that by the total, which was $2,544,446,548 and that's going to be roughly 2 percent. Or I could add those three together and divide it the same way and that's going to be approximately 98 percent.

Q. So, Categories 2, 3 and 4, if you added them together, come out to about 98 percent of the total?

A. That's correct.

Q. And, again, for the record, the total for all of these four categories is what, Dr. Rufus?

A. That's $2,544,446,548.00.

Q. Okay. So now, let's look more specifically at the prevention category which, as you said, is roughly 2 percent of the total, correct?

A. That's correct.

Q. Now, within this prevention category, there's an item or a category for harm reduction. Do you see that?

A. I do.

Q. How -- what's the dollar amount of that harm reduction category?

A. $19 -- $19,554,622.00.

Q. And do you have an understanding, Dr. Rufus, as to what's included in that harm reduction category?

A. Yeah. I -- I mentioned that earlier. This is not prevention. This is -- these include various strategies to reduce the harm of drug use.

Q. And, particularly, what kind of drug use? Do you have an understanding?

A. Well, it's -- Needle Exchange Program is the primary. Also, drug testing kits, HIV screening, things of that nature.

Q. So, is it your understanding that the harm reduction category is for IV drug users?

A. Yes, that's correct.

Q. And let me ask you, as well, to look at the first item under this category, which is for Health Professional Education. What's the dollar amount assigned to that category?

A. $5,437,224.00.

Q. And in your review of the city and the county budgets, have you seen any indication that the City and the County either fund or administer any programs to educate

prescribers on the prescribing of opioids?
A. I saw nothing related to education for prescribers, no.
Q. So, if -- again, I'm going to -- I'm going to dare to undertake some math with you. If you pull out Health Professional Education and Harm Reduction, could you tell me what remains in this Category 1 on prevention?
A. I will. Just give me one more -- well, wait a minute. It locked up on me again one more time. Yes. It equals $43,283,331.00.
Q. Dr. Rufus, I wanted you to subtract the Harm Reduction and Health Professional Education --
A. Oh, and the education --
Q. -- from the $48 million figure?
A. Okay. Okay. The net is $23,723,709.00.
Q. All right. Thank you.
A. I should have brought my own calculator.
Q. So, let's go back, if we can, to the treatment category. And I wanted to ask you a bit more about treatment costs. Dr. Alexander's calculations include numbers for the treatment for OUD, correct?
A. That's correct.
Q. And did you also look at Mr. Barrett's calculations of the costs for treatment?
A. I did, yes.
Q. And let me show you a demonstrative on this subject.

Did you prepare this demonstrative, Dr. Rufus?

A. I did.

Q. And could you describe generally, first of all, just at the top what this is relating to?

A. This is relating to the four levels of treatment that were contained in Dr. Alexander's plan. This is the formula at the top, number of people, average daily cost times the number of days, would give me the total cost.

Q. Let me pause you there.

A. Yes.

Q. So, when Dr. Alexander came up with his treatment levels, did he make an assumption about the number of people and the average daily cost and the number of days that would be involved in that treatment?

A. He did.

Q. And then, Mr. Barrett made those calculations?

A. That's correct.

Q. And what -- and let's focus first on the outpatient entry. What was his assumption about the number of days for outpatient treatment?

A. His assumption was 365 days.

Q. And so, in this first line item here, you show outpatient, an outpatient number of $971,357,386.00. What does that reflect?

A. That reflects the average cost of treatment times the

number of people in that particular category times 365 days.
Q. Does it reflect the average or the total?
A. The number is the total.
Q. Yes. So -- so, this outpatient number here, the $971 million dollars, what does that reflect?
A. That that's the total of -- that's the cost associated with that treatment program.
Q. And it's based on an assumption of what?
A. Of 365 days of outpatient care.
Q. Did you calculate the costs for that outpatient treatment using a different number of days?
A. I did. I went into George Barrett's report, his program, and changed the 365 days of outpatient care to 71 days.
Q. And what's the reason that you used 71 days to do the re-calculation?
A. Well, as I've referenced in my slide, it's for the TEDS 2018 survey data.
Q. What is the TEDS data?
A. TEDS data is treatment episodes and it's data that's published by SAMHSA.
Q. What's the significance of 71 days out of the TEDS data? What does that tell you?
A. That -- that -- what's the significance, that's a incredible source as to the average days of treatment in

that particular category.

Q. So, tell me what the 71 days is as found in the TEDS data. What does it reflect?

A. It reflects the average treatment period as compared to 365 days.

Q. So, if we use that TEDS number, you engaged in a re-calculation of Mr. Barrett's cost numbers based on that 71 days of treatment?

A. I did. And the difference was roughly $800 million dollars.

Q. So, let me just, for the record, put the numbers in. What's Mr. Barrett's number for outpatient treatment assuming 365 days?

A. It was $971,357,386.00.

Q. And what's -- if you calculate it using 71 days based on the TEDS data for the duration of treatment in 2018, what's the outpatient treatment number?

A. $188,948,971.00.

Q. And did you do the same sort of calculation changing the number of outpatient days for the other three days of categories in the treatment in the redress model?

A. I did.

Q. And how do you that at a rough level? What did you do?

A. At a rough level, I went into each category and where a 365-day number was used for outpatient care or whatever the

number had been used, I changed it to 71 for the max.
Q. So, let's just read into the record what you found for the three categories. What did you find for intensive outpatient? What was the change if you used 71 days of outpatient treatment rather than assumption of a full year?
A. I didn't put the change on my slide, but I can tell what the new number is.
Q. Yes. Just read off the number, please.
A. The number as calculated by George Barrett was $371,953,917.00. Recalculating that using the TEDS data resulted in an amount of $179,853,566.00.
Q. How about for rehab/residential, what was the -- what were the numbers?
A. The numbers calculated by George Barrett were $183,137,911.00. The recalculation was $111,910,346.00.
Q. And what about for the inpatient treatment as we've calculated using 71 days as an assumption for the outpatient part of treatment?
A. The amount calculated by George Barrett was $41,843,310.00 [sic]. The recalculated amount is $25,734,792.00.
Q. So, did you develop a total of the difference if you assumed this TEDS data using the 71 days of outpatient treatment versus the assumption in Dr. Alexander's model?
A. I did. And the difference is reflected on the bottom

of the screen. It's $1,061,849,848.00.

Q. Dr. Rufus, as part of your analysis -- let's switch to a new topic.

As part of your analysis, did you look at the basis for how Dr. Alexander derived his starting OUD population?

Maybe I should back up. You understand that the redress model is based on this starting OUD population that Dr. Alexander then used for his calculations?

A. Yes.

Q. And what's your understanding is the basis for how he derived the starting OUD number that then led through his model?

A. I didn't have a basis per se. He relied on information that was provided to him by Dr. Keyes in her calculations.

Q. And what year was -- did Dr. Keyes use in estimating the OUD population?

A. Her estimated OUD population was for 2018.

Q. And what year does Dr. Alexander's OUD population begin in?

A. In 2021.

Q. And did Dr. Alexander adjust the OUD population from 2020 to 2021?

A. From 2020 to '22 -- 2021, he did. He made a 4 percent adjustment.

Q. Did he make any adjustment in Dr. Keyes' 28 numbers for

the period between 2018 and 2020?

A. He did not.

Q. And do you have an understanding as to why he did that?

A. As to why he did not make an adjustment?

Q. Yes.

A. I don't, actually. I read his testimony and I don't think he ever clearly stated why he didn't do it.

Q. So, does Dr. Alexander's starting OUD population, which adjusted for 2020 over to 2021, did it make any adjustments for the changes during the period from 2018-2020?

A. No.

Q. Now, do you have an understanding that Dr. Alexander's redress model projects a reduction of overdoses and overdose deaths by 50 percent over 15 years?

A. Yes. I read his report and his scaling was as such, yes.

Q. Have you evaluated whether overdoses and overdose deaths have already decreased by roughly that amount in Cabell County and Huntington?

A. Yes, I have.

Q. And what data did you look at to determine this?

A. I looked at data from the West Virginia data dashboard. I've also looked at evidence that was presented during discovery regarding opioid overdose deaths and, as well as overdose cause.

Q. And let me show you a demonstrative. Did you prepare this demonstrative, Dr. Rufus?

A. I did.

Q. And what does this demonstrative reflect with respect to opioid overdose deaths in Cabell County?

A. Well, as you can see, it's done by year, by number, and what it reflects on the far right is a reduction in overdose deaths in Cabell County by 46.7 from 2017 to 2019.

Q. And what are the numbers for 2017 to 2018 and 2019 for opioid overdose deaths?

A. What are the actual numbers? 2017, it was 182. 2018, it was 137. 2019, it was 97.

Q. And that amounts to what, a percentage reduction of?

A. That's a reduction of 46.7 percent.

Q. Now, let's talk about suspected drug overdoses in Cabell County. What does this demonstrative reflect on overdoses in Cabell County?

A. It reflects an overall reduction from 2017-2019 of 52 percent.

Q. And could you read the numbers into the record for the Court from 2017-2019 for suspected drug overdoses?

A. Certainly. 2017, it was 1,831. 2018, it was 1,089. 2019, it was 878.

Q. So, Dr. Rufus, over this three-year period that you're looking at overdoses decreased by 52 percent and overdose

deaths decreased by 46.7 percent?

A. Yes, that's correct.

Q. What does Dr. Alexander's plan predict for a 15-year period?

A. He proposes a 50-percent reduction over the 15, over the 15-year period.

MR. HESTER: Thank you, Dr. Rufus. Those are all the questions I have.

I'll pass the witness.

MR. MAJESTRO: Your Honor, he's cut out a bunch from his report. I think if we could take a 15-minute break, I could probably cut my cross by about -- by over half an hour.

THE COURT: Okay. We'll be in recess.

You need about 15 minutes?

MR. MAJESTRO: Yes, sir.

THE COURT: All right. We'll be in recess until a quarter after 10:00.

(Recess taken)

(Proceedings resumed at 10:15 a.m. as follows:)

THE COURT: Mr. Rufus, you can resume the witness stand, sir.

MR. MAJESTRO: Ready, Your Honor?

THE COURT: Yes, Mr. Majestro.

MR. MAJESTRO: Thank you.

Gina, can you bring up their Demonstrative Slide Number 1? Maybe on the last day I'll figure out how to work this.

BY MR. MAJESTRO:

Q. All right, Dr. Rufus, the -- your Table 2.13, the costs you allege were expended by the city and county on the opioid epidemic -- first of all, you don't challenge Dr. Alexander on what was medically necessary, his testimony on what is medically necessary for his abatement proposal; correct?

A. I do not. That's correct.

Q. What the city and county spent is a fraction of that number; correct?

A. Yes, that's correct.

Q. What the city and county spent is not necessarily what is needed; correct?

A. That's probably true.

Q. It might be more of a reflection on the city's -- city and county's ability to pay; correct?

A. No, I don't think it has any -- I'm sorry. Was there an objection?

I don't think it has anything to do with their ability to pay at all. I think -- for example, I think Mayor Williams stated it best is they're not in the business of providing healthcare. That's not what they do. That's not what city government does. And it's certainly not what

county government does. So it's not a matter of capacity to pay. It's a matter of function.

Q. So you're -- well, we'll leave it at that.

Let's go to Slide 3. I'm sorry, Slide 2.

So the category -- I'm going to make the math easy for us.

A. Okay.

Q. In Category 2B, what's the number under Mr. Barrett's calculations of Dr. Alexander's abatement plan?

A. $1,705,896,182.

Q. Okay. Let's remember that number.

Then if we can go back to Slide 4.

Your testimony by dropping the days to 71 -- first of all, Dr. Alexander's 365 days is not -- his testimony is not that each person would need an average of 365 days. It's a weighted average. Correct?

A. Well, it's a weighted average cost. It is an incorporation of outpatient treatment days equaling 365 days for each component year but, but it's a component cost in the other three levels, that's correct.

Q. Okay. And that's not the case with the 71 days under the test data; correct?

A. I'm not sure -- I'm not sure what the question is.

Q. That it's not -- the 71 days is not a weighted average cost?

A. It's, it's an average time -- average treatment program plan for outpatient care.

Q. Okay. So I'm going to bring the calculator -- I'm going to have you bring the calculator back. And to make this easier, we're going to, we're going to lop off the last three, the last three digits.

Let's take the one million -- one billion seven hundred five thousand eight hundred ninety-six and change it to 1,705,896.

A. Are you changing that where?

Q. So let's take -- go back to Category 2B from Slide 2. Just for ease of math, you can, you can remove the last three digits.

A. Okay.

Q. Thousand millions instead of billions. Okay. So --

A. Yeah.

Q. So one seven zero eight nine six minus your total difference of one zero six one eight four nine.

A. Okay.

Q. What have you got?

A. Well, I wasn't actually doing the math because I don't have a calculator.

Q. Oh, sorry.

MR. HESTER: I'm sorry.

THE WITNESS: I should have brought my own

calculator.

BY MR. MAJESTRO:

Q. The iPhones work the best. You just turn them sideways and you can go out to billions.

Okay. Let's try again. 1,705,896 minus 1,061,849.

A. It's too small for me. 706,896?

Q. Yes.

A. One million -- 1,706,896 minus 1,000,061?

Q. Yes.

A. My screen just went out. There we go. Actually, I've got that number. Hold that screen for just a second, the next screen. 705,896 minus -- the next screen -- minus 1,061,849 equals 644,047.

Q. And that would -- and we add the three numbers -- the three zeros back and it would be -- so what would the total be?

A. If we added the three zeros back, it would be 644 million.

Q. Okay. And, so, based on your, your use of the TEDS data, the number would be 644 million?

A. Assuming we just did the math together correctly.

Q. That's what I got, so I think there's a reasonable chance that we're correct. And the -- and under Dr. Alexander and Mr. Barrett's calculations, it would be roughly 1.7 billion?

A. That's correct.

Q. So we have a range between those, those two numbers of approximately a billion dollars. But if the Judge -- if the Judge agreed with your number, we'd get 644 million. If the Judge agrees with Dr. Alexander and Mr. Barrett, it's 1.7 billion, or the number could be anywhere in between?

A. That's correct.

Q. That's all I have. Thank you.

THE COURT: Any redirect, Mr. Hester?

MR. HESTER: No redirect, Your Honor.

THE COURT: May Dr. Rufus be excused?

(No Response)

THE COURT: Thank you, sir. You're free to go.

THE WITNESS: Yes, Your Honor.

MS. WICHT: Your Honor, while we're getting set up for the next witness, we have a few Cardinal Health documents to move into the record. May I approach and do that while we make the changeover?

THE COURT: Yes.

MS. WICHT: Thank you, Your Honor.

By agreement and stipulation with the plaintiffs, Cardinal Health is moving the following exhibits into the record. And I have a thumb drive to hand up to the clerk.

The exhibit numbers are CAH-WV-65, CAH-WV-70, CAH-WV-73, CAH-WV-103, CAH-WV-104, CAH-WV-476, CAH-WV-562,

and finally CAH-WV-564. And by agreement of the parties, those documents -- we ask to have those documents admitted to the record.

THE COURT: All right. There being no objection, they're all admitted.

MS. WICHT: Thank you. May I approach with the thumb drive?

THE COURT: Yes.

MS. WICHT: Thank you.

MS. MCCLURE: Good morning, Your Honor. The defense calls Ms. Stephenie Colston.

THE CLERK: Would you please state your full name?

THE WITNESS: Stephenie Webber Colston.

THE CLERK: I'm sorry. What was the middle name?

THE WITNESS: Webber.

STEPHENIE WEBBER COLSTON, DEFENDANTS' WITNESS, SWORN

THE CLERK: Thank you. Please take a seat.

THE COURT: Good morning, ma'am.

THE WITNESS: Good morning.

DIRECT EXAMINATION

BY MS. MCCLURE:

Q. Good morning, Ms. Colston.

A. Good morning.

Q. Could you please introduce yourself to the Court?

A. My name is Stephenie W. Colston.

Q. And, Ms. Colston, what is your current occupation?

A. I am President and Chief Executive Officer of Colston Consulting Group.

Q. And what does Colston Consulting Group consult about?

A. My company consults about mostly behavioral health services, programs. That includes both mental health and substance use disorder services, though I have to say in the last few years that I've been doing this, this last seven, it has been probably 95 percent substance use disorder services.

Q. And who do you advise in that consulting capacity about substance use disorder?

A. A very diverse clientele, including state governments, local community substance use disorder providers. I have worked with Pew Trust, for example, on a report that, that the trust did on substance use disorder funding throughout the country. Gosh. I've consulted with municipalities about substance use disorder services and faith-based organizations.

Q. And how long have you been in this consulting role for substance use disorder?

A. Since January of 2013.

Q. And, Ms. Colston, did you put together a few slides that outline your educational experience -- educational background and professional experience?

A. I did.
Q. And would it assist you to pull those slides up --
A. Yes, it would.
Q. -- as we go through your testimony?
A. Yes. Thank you.
Q. Okay.

MS. MCCLURE: Your Honor, I'd publish Demonstrative Number 1.

THE COURT: Yes.

BY MS. MCCLURE:

Q. Could you explain to the Court what your educational background is?
A. Yes. All of my degrees are from the University of Oklahoma, thus the logo I guess. Bachelor's Degree in sociology; Master's Degree in political science; and for a number of years I held all but dissertation status in the political science department, but my area was federal, state, and local public administration.
Q. And did that also include federal, state, public administration for that all-but-dissertation status of substance abuse funding?
A. It did. Actually, a substance abuse block grant was the topic of my dissertation.
Q. And let's move on to the next slide, Demonstrative 2, your work history. What was your first job experience

focusing on substance use and abuse?

A. The Chief of Operations for the Oklahoma Department of Mental Health and Substance Abuse Services.

Q. And what years was that?

A. 1982 to 1984.

Q. And as Chief of Operations of the Oklahoma Department of Mental Health and Substance Abuse Services, what were your job responsibilities?

A. I was responsible for all operations of department state-operated and state-funded services throughout the entire State of Oklahoma.

Q. So did that include finance, personnel, or performance, conducting audits?

A. Yes. It included all of the financial operations of the department. It included human resources. It included audit services where -- that were both clinical and financial in nature. It included all of the data that the department gathered from the providers and reported through the federal government.

Q. Okay. Now, you're not a clinician; right?

A. That's correct.

Q. But you had oversight in the operations role of the entire department; correct?

A. Correct.

Q. And did you move to another position within that

organization?

A. I did. I -- in 1984 I became Inspector General.

Q. And is that -- that's not on the slide. So between '84 and '85 you had another role with the Oklahoma Department of Mental Health and Substance Abuse; correct?

A. Yes, that's correct.

Q. And what's the Inspector General? What were your primary responsibilities in that role?

A. Well, the Inspector General basically investigated all complaints about employees or services relating to individuals within the department's care.

Q. Did it also include investigations of the services that are funded by the department?

A. It did.

Q. Okay.

A. Yes.

Q. And then what did you do after that?

A. As a result of an investigation, I determined some quality of care and financial problems -- excuse me -- with one of our major state-operated community mental health centers and made several recommendations about employees and leadership.

And then the -- my boss, the commissioner, asked me to become the Executive Director and Chief Executive Officer of that center and basically turn it around.

Q. And did you, in fact, become CEO of that community mental health center?

A. Yes, I did from 1985 to 1988.

Q. '85 to -- I'm sorry. What year?

A. '88.

Q. Can you describe that facility for the Court? Is it just one, one facility or is it broader?

A. The center was what is called the Comprehensive Community Mental Health Center and was at the time considered to be a one-stop shop for an eight-county catchment area in Southwestern Oklahoma.

And I had three satellite offices in three of those eight counties. And then the main center with all of its services was in Lawton, Comanche County, Oklahoma.

Q. And can you very briefly at a high level describe the kind of units that were in that main center in Lawton, Oklahoma?

A. Yes. We had a psychiatric intensive care unit which typically involved legally-involved individuals brought into the police and the sheriff's office. We had mental health residential services. We had substance abuse outpatient and residential services, mobile crisis -- I'm missing -- transitional housing.

Q. Is it fair to say that that facility involved the complete continuum of care for mental health and substance

abuse?

A. Yes.

Q. And between 1982 and 1998 -- I'm sorry. Let me start over. Between 1982 and 1988 was mental health and substance abuse treatment changing?

A. Yes. During my tenure at the Oklahoma Department of Mental Health Services, we basically moved the entire system from a hospital-based system to a community-based system.

Q. And, so, approximately how many patients when you started that position in -- or with this department in 1982, how many mental health and substance abuse patients would have been in an inpatient capacity?

A. Probably 90 percent --

Q. And by --

A. -- of them.

Q. Okay. And by 1988, about how many patients were in a community-based capacity?

A. About 50 percent.

Q. And were there any credentialing or status concerns at this facility when you took it over in 1985 in terms of Joint Commission or Medicaid?

A. Yes. There were, there were clinical leadership issues. There were patient care issues. There were general quality of care issues. And the facility was just about to lose its Medicare certification, and because of its deemed

status, its Joint Commission accreditation status.

Q. So let me just understand the last thing you said about deemed status. If you lose your Medicaid and Medicare status from the federal government, what does the Joint Commission think or do about that in your experience?

A. Well, the deemed status typically means -- this is mostly Medicare for, you know, a state facility like that. If, if you enjoy Medicare certification, you are deemed to be eligible and meet Joint Commission standards.

Q. And if you don't meet Medicare certification, what's the Joint Commission --

A. Not only will Medicare come visit you, but the Joint Commission will come visit you.

Q. And how about the reverse? If you lose your Joint Commission status, do you also put your Medicare and Medicaid reimbursement status at risk in your experience?

A. Yes, yes.

Q. Okay. And, so, what were your primary responsibilities at this mental health facility?

A. I was in charge of all -- everything that happened at the facility I was responsible for it.

Q. And how long were you in that position?

A. Three years.

Q. And then how about -- what was your next position after that?

A. I was recruited to work for a psychiatric facility that was a for-profit facility in Richmond, Virginia.

Q. And how long did you hold that position?

A. Three years.

Q. And what was your next position? We are now at 1991; correct?

A. Yes. I went to work for a federal contractor, a government contractor in the DC area.

Q. And with what agency specifically did that federal contractor have a contract with?

A. The Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services.

Q. Okay. And did you prepare a slide about what SAMHSA is for the Court today?

A. I did.

Q. Okay.

MS. MCCLURE: If we could pull up that slide.

BY MS. MCCLURE:

Q. So what is SAMHSA?

A. SAMHSA is the federal agency that is responsible -- one of its responsibilities is to administer both the substance abuse and mental health block grants. For example, the Substance Abuse Block Grant is the largest line item in SAMHSA's budget. So it's a huge, huge grant for the

country.

And then SAMHSA also distributes targeted -- and by that, it could be, for example, opioid use disorder -- discretionary funding for both mental health and substance abuse services.

Q. Okay. How long were you in the SAMHSA federal contractor position?

A. From 1991 to 2003.

Q. And what were your job responsibilities?

A. When I began, I was the team leader for the State Technical Reviews Project. And --

Q. Let me stop you right there. Technical reviews, what is a technical review? It sounds like it could be IT. Is it IT related?

A. No, ma'am, not necessarily at all. We would -- we brought teams together of experts in, in substance abuse clinical, financial, and managerial activities.

We would go to a state -- and I would guess I personally participated in about 65 percent of, of the state reviews -- and often would spend a month there interviewing and understanding everything that happened at the state agency realm. So in this particular case, that would be the West Virginia Department of Health and Human Resources, and how the federal block grant money flows from the state level either directly to community substance abuse providers or

through a regional entity and then to the provider.

Q. And I think you said it was a team. Was your role often as the team leader?

A. Yes.

Q. When you said you participated in probably 65 percent of the state reviews, did you personally travel to states to conduct these technical reviews of how the state was distributing the block grant money?

A. Yes.

Q. And, so, the purpose -- am I right -- is to establish compliance, that the state is complying with the federal government rules, regulations for distribution of that fund?

A. Correct.

Q. And in connection with those reviews, did you review documents from the state?

A. Yes. We had very specific protocols and procedures. We pre-site. We would request, oh, gosh, hundreds of documents probably from the state each -- in each of those three areas; management, clinical, finance. And the team member assigned to that category would review them.

From that information, we would develop an interview list, send it to the state, create a schedule of on-site interviews. And then we would actually begin the reviews. We always gathered additional documents on-site.

Q. And what, what was the end product? At the conclusion

of a state technical review, what, what was the end product that you would deliver?

A. A report was provided to the Substance Abuse Mental Health Services Administration and the state with our recommendations about compliance.

Q. Okay. And, so, you said you started there as team lead in 1991. What was your role by the time you left in 2003, 12 years later?

A. I was a Vice President in the company and it was one of several projects within my portfolio.

Q. So that first technical review, I think you said that was treatment related. What were the other projects in your portfolio by the time you left in 2003?

A. A very similar project to do state substance abuse prevention reviews, and then a project to provide training and technical assistance to substance abuse community-based provider organizations throughout the country to improve basically their business practices.

Q. And then what was your next position in 2003?

A. I was asked to be the senior substance abuse adviser for the SAMHSA administrator.

Q. Okay. And is the SAMHSA administrator in the federal government a presidential appointee?

A. He is a presential appointee and Senate confirmed, has that status.

Q. Okay. And how many senior advisers did the SAMHSA administrator have in this time period when you were there from 2003 to 2005?

A. Two.

Q. Okay.

A. One for mental health, one for substance abuse.

Q. And which, which role did you have? The mental health or the substance abuse?

A. Substance abuse.

Q. And, so, what, what were your job responsibilities as the senior adviser for substance abuse to the SAMHSA administrator?

A. In the federal government there is something called the Senior Executive Service which is pretty much the highest before you become an administrator. It was a Senior Executive Service equivalent position, but I was hired as a special expert. And I was basically his confidential adviser on any and all things related to substance abuse that SAMHSA dealt with.

I regularly represented him in congressional testimony -- I did that once -- but mostly to internal and external stakeholders, internal staff, represented his interests, represented his direction, gave direction to center directors relating to his, his priorities.

Q. Did you have any responsibility for anything related to

the block grants in this time period from 2003 to 2005 for substance abuse?

A. Anything that related to the substance abuse block grant, I -- if, if it rose to the level of the administrator's office, I was involved in it. And mostly I was involved in it because of my expertise with that topic.

Q. And did this job include any policy-making role?

A. It included a fairly significant level of policy; again, representing his priorities, making sure that his policies and, frankly, the White House policies were adhered to, and working through with the staff how to implement those policies.

Q. Strategic planning responsibility?

A. Lots of strategic planning. We did a lot of -- we did a review of both the mental health and substance abuse block grants and how they could be improved to assist states and have fewer set-asides.

Q. Now, that was '03 to 2005. I believe it was the full three years. Correct?

A. Correct.

Q. Did you have any further detail during that time period?

A. Yes, I did.

Q. Tell us about that.

A. Okay. I was detailed to the White House Office of

National Drug Control Policy in 2004 for a period of four months.

Q. And what was your title in that position?

A. I was the Senior Adviser to the ONDCP Director for Demand Reduction.

Q. What's Demand Reduction?

A. It is the prevention and treatment, basically, system in the country.

Q. And were there any particular crises or issues that were -- that came up during this four-month time period when you were detailed?

A. Oh, gosh. Probably the most challenging was -- there were several. And there would be briefings, of course, at ONDCP daily that were -- had various levels of clearance. And, for example, it could be anything from coca leaves to Mexican heroin. So those briefings were generally classified.

Q. And to be clear, I'm not asking you to divulge classified information.

A. Well, thank you so much.

Q. I'm just trying to get a sense -- was there a meth crisis at the time?

A. There was absolutely a methamphetamine crisis. And we had many discussions with the Drug Enforcement Administration about supply and demand. We were trying

to -- from the demand perspective, we were trying to explain that there were people who had legitimate reasons for taking pseudoephedrine. Some of us have allergies. And the DEA was pretty focused on the supply; let's just get them off the shelves. So we would have lively discussions about the differences and the approach between supply reduction and demand reduction.

Q. Okay. Let's, let's head back to the Demonstrative 2 about your work history. What was your next position in 2005?

A. I came back to Florida. I had moved there. I came back to Florida as the Single State Authority for Substance Abuse, a substance abuse director.

Q. So who was your employer then?

A. The Florida Department of Children and Families.

Q. And what -- so that's a State of Florida employment?

A. Yes.

Q. And what years were you in this position with Florida?

A. Actually, when I was hired -- I forgot to say -- I had two positions, the Director of Substance Abuse for the Department of Children and Families and Deputy Director for Treatment for the Governor's Office of Drug Control. So I had both of those positions.

Q. And what were your primary responsibilities in this role as Director of Substance Abuse for Florida?

A. Basically responsible for all of the -- the distribution of all funds, federal state, to the providers; had major strategic planning roles; and did any number of -- we were primarily responsible for monitoring the funding and the programs. So there were -- it was a very active time and we were pretty much operating a system of care that was very complex for about 19 million people.

Q. And I think you used the phrase Single State Authority. What is -- what does Single State Authority mean?

A. It's a, it's a federal term that the Substance Abuse and Mental Health Services Administration uses to designate an agency to be responsible for either the mental health or the substance abuse block grant.

Q. And, so, is that an agency, one agency in every state?

A. Yes.

Q. And, so, when you say that you were the Single State Authority for Florida, is that by virtue of you holding the title of Director of Substance Abuse for the Department of Children and Families?

A. Yes. The Governor designated --

Q. Okay.

A. -- that office. And then whoever is the Director of that office is the Single State Authority.

Q. And, so, from 2005 to 2012 you were the Single State Authority responsible for distributing block grant funds and

strategic planning for the State of Florida substance abuse?

A. That's correct.

Q. And then in 2013, is that when you started your consulting company?

A. Yes.

Q. And what kinds of activities -- we talked a little earlier about the kinds of clients that you have in this consulting capacity. But what types of activities have you been performing in this consulting role since 2013?

A. I have assisted the state over a five-year period of time to design and develop their 1115 Medicaid Substance Use Disorder Waiver.

I have worked with faith-based organizations to assist them in becoming Medicaid eligible. I have worked with a variety of community-based organizations to help them become Medicaid certified and be able to treat the Medicaid population.

I have -- oh, gosh, I'm trying to remember.

Q. Have you been hired by the federal government in this role --

A. Oh, yes, I have. I'm sorry.

Q. -- since 2013?

A. Yes, I have. I have basically been asked to be a federal grant reviewer, a peer reviewer for the medication assisted treatment, PDOA, prescription drug overdose,

federal grant that is distributed to not only state governments, but directly to community-based organizations.

Q. And have your roles since 2013 advising your various clients included strategic planning and sustainability analyses?

A. Yes. You know, it's -- the funding environment has been challenging for substance abuse providers. And I've done a good bit actually of strategic planning to try to help community-based substance abuse organizations become more stable both financially and, frankly, programmatically. And I have done a lot of sustainability planning for boards.

Q. And were you selected by SAMHSA to become -- to be a Medicaid SUD specialist and provide technical assistance to states in this capacity?

A. Yes.

Q. And, Ms. Colston, have you ever testified before as an expert?

A. No.

Q. What's your hourly rate for expert work in this matter?

A. For testimony or non-testimony?

Q. How about both?

A. Okay. For non-testimony my rate is $350 an hour. And for testimony it is $750 an hour.

Q. And approximately how much time would you estimate you've spent in total reviewing materials and preparing both

your report and for testimony in this case?

A. I would, I would estimate over 500 hours.

Q. And, so, since your report is it -- you've continued to review materials; is that right?

A. I certainly do. I -- that's my job.

Q. And you're aware that we've updated your materials; correct?

A. Yes, I am.

Q. And what was the purpose of you reviewing materials since your report in preparation for your testimony here today?

A. So that I remain current on what is occurring.

Q. And do those materials confirm your judgments that you had already issued in your report?

A. Yes.

Q. And, so, what were you asked to do in connection with this case? What, what kinds of materials? What kinds of analyses?

A. I was asked to review the West Virginia substance abuse system and the landscape of substance abuse programs throughout the system of care in West Virginia.

I was asked to review the financing of substance use disorder services throughout the West Virginia system of care. And that would include Medicaid, block grants, state.

I was asked to review the Cabell County and City of

Huntington substance use disorder program landscape I would call it, how many providers are there. And, and I was asked to review the financing of those.

I was asked to review Dr. Alexander's -- I believe the title is his abatement plan, his plan to address the opioid crisis. And I think that's it.

Q. And I believe you said that the City of Huntington and the county's programs and services. Do you have an understanding as to whether the programs and services you reviewed are actually city and county programs or whether they are the programs and services located in the county?

A. Located in Cabell County, Huntington.

Q. And did you also become familiar with, with data relating to substance use and opioid use disorder in West Virginia and Cabell County?

A. Yes, and trends, frankly, across.

Q. Okay. And, now, we've gone through your work history. So let's summarize briefly your experience with substance use disorders.

MS. MCCLURE: And, Ritchie, if we could bring up Slide Number 4, please.

BY MS. MCCLURE:

Q. Let's start with financing. Do you have experience with financing and funding?

A. Yes. I think the -- probably the, the experience

that's most relevant here is the diversity. And that's, that's represented by my Colston Consulting Group.

Right now I -- I'm involved in just about every aspect of financing on behalf of either states or community-based organizations or, you know, like the Pew thing.

Q. And you have experience with Medicaid and the state plans --

A. Yes.

Q. -- as well as waivers?

A. Yes. And probably the most relevant with Medicaid and waivers is my work with the State of Alaska on their 1115 SUD waiver.

Q. Okay. And we'll get into what that is a little bit later.

A. Okay.

Q. So just keeping with your experience, you have experience with the SAPT block grants? That's the Substance Abuse Prevention and Treatment block grants?

A. Yes, the state reviews that I mentioned earlier.

Q. And targeted discretionary funding? You have experience with that?

A. Yes. I learned the most during my experience with SAMHSA about that.

Q. And how about historical substance use trends?

A. Again, I think, I think really paying attention to

trends and, and developing policy based on those would have been at SAMHSA and the White House Office of National Drug Control Policy.

Q. And Florida as well?

A. And Florida as well, yes.

Q. And same thing, program operations, you have experience in that area?

A. I do. I've run them. I work with community-based organizations now. I did reviews of them for 12 years. So I -- that's one of those cross-cutting categories.

Q. And how about that last category, needs assessment? Do you have experience with needs assessment?

A. I was asked to do a -- well, of course, I've reviewed many state needs assessments because it's a block grant requirement, or it always has been.

And I was -- when I was Vice President at the government contracting company that I worked for, I was asked to do a white paper, I guess I would call it, on how states conduct needs assessments and the quality thereof.

Q. Okay. So in these areas -- in the area of substance use disorder, you have worked for the federal government, at a state level, as a provider, as well as a consultant at all of -- worked as a consultant advising all of those?

A. That's correct.

MS. MCCLURE: Your Honor, at this time I would

tender Ms. Stephenie Colston as an expert in the area of systems, programs, and services that provide care for people with substance use disorder, their structure, financing, and how to assess them, and trends in the substances that are being abused.

THE COURT: Is there any objection?

MR. FARRELL: No, Your Honor.

THE COURT: The Court finds Ms. Colston to be an expert in the area of systems, programs, and services that provide care for people with substance use disorder, the structure, financing, and how to assess them, and trends in the substances that are being abused.

Did I get that right, Ms. McClure?

MS. MCCLURE: You did. Thank you, Your Honor.

BY MS. MCCLURE:

Q. Now, Ms. Colston, are you here today to provide an opinion as to the cause of the opioid epidemic?

A. No, I'm not.

Q. Are you here today to provide an opinion on diversion?

A. No, I'm not.

Q. Are you here today to provide an opinion as to what plaintiffs have referred to as the gateway theory?

A. No.

Q. And are you here today to provide an opinion on the conduct of distributor defendants?

A. No.

Q. Okay. Let's talk about funding the federal government provides to states municipalities and provider organizations for substance abuse.

MS. MCCLURE: And, Ritchie, if we could --

BY MS. MCCLURE:

Q. Did you prepare a demonstrative that would assist with this portion of your testimony?

A. I did.

Q. Okay.

MS. MCCLURE: If we could pull up Demonstrative 5.

BY MS. MCCLURE:

Q. Okay. And what broad categories or types of funding does the federal government provide for substance abuse?

A. For our purposes, the Substance Abuse Prevention and Treatment block grant, the targeted and discretionary grants from the federal government that I, that I spoke about earlier, Medicaid, and Medicare.

Q. Okay. So there's four buckets up there. Let's walk first through the SAPT block grant, the Substance Abuse Prevention and Treatment block grant.

MS. MCCLURE: If we could populate that, Ritchie.

BY MS. MCCLURE:

Q. Okay. So you discussed this earlier in your

testimony about your background in Florida, the Single State Authority. That was your role in Florida?

A. That's correct.

Q. Okay. So is the entire SAPT block grant intended for substance abuse?

A. Yes.

Q. Do you know what the national amount of that SAPT block grant is?

A. $1.8 billion.

Q. Okay. And do you know what fiscal year that was for?

A. '19.

Q. And that's for the country?

A. Yes, ma'am, every state and territory.

Q. So describe how the SAPT block grant works for the Court.

A. Well, the SAPT block grant is distributed from the federal government to the Single State Authority. And depending on the structure of the substance abuse system in that state, the money can flow either through a regional entity, which some of the block grant money does here in West Virginia. For Cabell County, that would be Prestera. And then the money can be distributed from the Single State Authority directly to community providers.

Q. Okay. So let's pause there for a minute. You said that the federal government gives each state an amount?

A. Correct.

Q. How does the federal government decide what that amount is?

A. There's a congressional formula that is mandated. And it is based on population, income, or cost of services, not income -- I'm sorry -- and a financial index.

Q. And is every state and territory eligible to receive the SAPT block grant?

A. Yes.

Q. And when you say the congressional formula, who then executes that formula and applies that congressional formula in doling it out?

A. The Substance Abuse Mental Health Services Administration.

Q. SAMHSA?

A. SAMHSA, yes.

Q. And what is the purpose of the SAPT block grant? What does it cover?

A. For -- historically, the block grant has covered I would say probably 75 to 80 percent of substance abuse services throughout the country. You know, within about the last 15 years, Medicaid has become a primary payer of substance use disorder funding. But traditionally SAPT was pretty much all some of us had out there.

Q. And that 75 to 80 percent figure, you're using that

historically --

A. Yes, ma'am.

Q. -- and -- okay. And who -- what, what individuals would be anticipated to receive block -- services and programs that come through this block grant funding?

A. Generally, states distribute the block grant to individuals who are not Medicaid eligible, who are not Medicare eligible, and don't have private insurance, so the individuals that remain.

Q. So it doesn't go directly to individuals. It goes to programs and services --

A. Correct. It goes to providers.

Q. Let me just -- she can only take down one at a time. So let me make sure I finish my question.

A. Okay. Sorry.

Q. It's okay. So the money goes through the federal government to the Single State Authority to then programs and service providers to provide services to those low income individuals who may not qualify for Medicare or Medicaid. Do I have that right?

A. You do, though it may pass through a regional substate entity. And that could be a county government. It could be --

Q. And is the SAPT block grant just or only intended to provide individuals with medicine or is it broader than

that?

A. It's much broader than that. It includes that, but it, it basically supports psychotherapeutic outpatient services and intensive outpatient services and partial hospitalization.

There is a 20 percent financial set-aside for prevention programs to be certain that prevention programs are provided in states throughout the country.

And there are set-asides for women, pregnant women and women with dependent children and injecting drug users.

So there are a series of requirements in that block grant that states have to comply with.

Q. And, so, does a set-aside mean that the state has to insure that that portion of the funds that go to that state are set aside to cover a particular kind of population?

A. Yes.

Q. Okay. But all of the SAPT block grant services, whether it's medication or psychotherapy or peer recovery, is all related to substance abuse; correct?

A. That's correct.

Q. And, so, once the federal funds are designated, what happens next for a state?

A. The state distributes the, the funding to whatever entities, you know, based on the structure of the state that I mentioned earlier. And then the community-based

organizations provide the services in compliance with federal requirements.

Q. So some states, is it fair to say, provide funds directly to regions I think you said? Some states provide funds to programs and service providers directly; right?

A. That's correct.

Q. And do some states decide to provide funds through the county system?

A. Yes, they do.

Q. Okay.

A. Many do.

Q. And how about West Virginia, if we could talk about the West Virginia piece for a minute. What's your understanding as to how SAPT block grant money is distributed by the Single State Authority for West Virginia?

A. Well, the block grant application for federal fiscal years '20 and '21 reported that they, they distribute the money -- they have six regions throughout the state. And within those six regions, they have 13 comprehensive behavioral health centers that are responsible for ensuring a continuum of care in their region. In Cabell's case, it is Prestera Center. And --

Q. Let me pause there for a minute.

A. Sure.

Q. One of the 13 comprehensive community behavioral health

centers for the State of West Virginia is located in Cabell County?

A. That's correct, the largest actually.

Q. Okay.

A. And they indicated that they also distribute block grant money directly to community providers.

Q. Do you know what portion -- after those set-asides that you previously discussed, what portion of the SAPT block grant distributed to West Virginia has been allocated by West Virginia for treatment and recovery support?

A. I think it ranges from 70 to 80 percent.

Q. How long has this SAPT block grant been in existence at the federal level?

A. Since 1982.

Q. Any changes recently to the amount of the SAPT block grant awarded to West Virginia?

A. Yes. West Virginia for the past many years has been receiving approximately 8.4 million a year. For 2021 they received 23.1 million dollars.

Q. Okay. Now, let's talk about this next bucket of federal funding for substance use disorder, targeted and discretionary funding. What kinds of grants or federal funding is there under these categories?

A. The major --

Q. I think that you may have --

A. I do. I was just trying not to turn this way. I'm happy to do that.

The first major funder would be the Department of Justice. And in my report I talk about the amount of money that came to West Virginia and probably Cabell County. I did actually.

But, for example, funding drug courts throughout West Virginia and in Cabell County, this money was used to fund the Women Empowerment Addiction Resource, I believe, W-E-A-R program --

Q. Uh-huh.

A. -- which is kind of a novel program.

The Centers for Disease Control and Prevention is the next major category. And West Virginia received a state opioid surveillance system grant and then an enhanced grant. They call it ESOOS, E-S-O-O-S. And that basically was used -- part of that funding was used to develop the Office of Drug Control's data dashboard on overdose deaths.

Q. Is that the DHHR dashboard?

A. Yes, yes. I'm sorry. It is. And, so, you can monitor any number of things through that dashboard. It's quite good.

The next organization is HRSA, the Health Resources Services Administration. They generally fund federally qualified health centers throughout the country. But they

also have the rural opioid community program that they've been funding, and Prestera Center has received some of that funding.

Q. So is that additional funding that Prestera and Cabell County received on top of the SAPT block grant that you previously talked about?

A. Yes. And then, of course, last but certainly not least SAMHSA has provided the bulk of opioid-related discretionary funding to West Virginia and other states.

Q. Okay. Let's start with that first grant on the left, the STR. What does that mean?

A. The State Targeted Response grant was pretty much the first SAMHSA grant to -- provided to states regarding the opioid crisis.

Q. And what years was that provided in?

A. 2017 and 2018.

Q. Now, are you aware of how much funding West Virginia received pursuant to the STR?

A. 5.88 million a year, which would be just under 12 million. But --

Q. Go ahead.

A. No. That's all right.

Q. Are you aware of a March, 2020, report titled States' Use of Grant Funding for a Targeted Response to the Opioid Crisis prepared by the Office of Inspector General for

Health and Human Services?

A. I am.

MS. MCCLURE: And, Your Honor, may I approach?

BY MS. MCCLURE:

Q. Now, Ms. Colston, is this the report, the title I just read, States' Use of Grant Funding for a Targeted Response to the Opioid Crisis?

A. Yes.

Q. And who issues this -- who issues this report?

A. The United States Department of Health and Human Services Office of Inspector General.

Q. Just try to stay a little closer to the microphone.

A. The United States Department of Health and Human Services Office of the Inspector General.

Q. And have you seen this report before?

A. Yes, I have.

Q. And did you, in fact, rely on it in your report?

A. I did.

Q. And if we turn to --

MS. MCCLURE: Ritchie, could you pull this document up on the screen?

BY MS. MCCLURE:

Q. If we turn to the second page past the cover, the page right after this, and at the top can you read that first sentence under what OIG found?

A. "More than 300 million dollars, almost a third of the total nationwide grant funding for the state targeted response to the opioid crisis grant program, remained unspent after two years."

Q. And, so, that's a national total; correct?

A. Yes.

Q. Okay.

MS. MCCLURE: And, Your Honor, at this time I move the admission of this DEF-WV-03237 into evidence.

THE COURT: Is there any objection?

MR. ACKERMAN: The objection I have, Your Honor, is hearsay. And the issue I have is that this is an expert witness who certainly can testify that she relied on the document. But in terms of setting a foundation to establish a hearsay exception, I don't know that the witness has any knowledge outside of what's stated in the document.

MS. MCCLURE: Your Honor, the document itself reflects on the cover of it and the face of it this is similar to the OIG report that was admitted via Chris Zimmerman's testimony. It's a different report, but it is Office of Inspector General report in the Health and Human Services. I can speak with the witness briefly regarding some additional foundation.

BY MS. MCCLURE:

Q. Ms. Colston, are you aware of reports issued by

Offices of Inspector General as a general concept?

A. Yes, I am.

Q. And, in fact, were you an Inspector General for a time period in a state?

A. Yes.

Q. And, so, is it your understanding that if -- that reports issued by Inspector Generals are official reports issued by public entities reflecting the, the information and materials that the agency is expected to and has a responsibility to report on?

A. Yes.

Q. Okay. And this document is indicated on the face and the cover of it that it was issued by the Deputy Inspector General for Evaluation and Inspections for Health and Human Services in March, 2020; correct?

A. Yes.

MS. MCCLURE: And, Your Honor, I believe that pursuant to the public records exception, 803(8), this is a civil case and this reflects factual findings from what appears on the face of the document to be legally authorized investigation of the Health and Human Services Administration.

THE COURT: Mr. Ackerman.

MR. ACKERMAN: Your Honor, I'm not sure that testimony cures the objection. All the witness testified

was what the face of the document said and that she was -- and that she was familiar with these types of reports.

Again, I have no issue with an expert witness testifying as to what that expert relied on and why. I do have an issue with an expert witness seeking to have a document moved in for the truth of the matter asserted through a witness who had no personal knowledge of the document other than the fact that it was something that the person relied on in their report.

MS. MCCLURE: Your Honor, personal knowledge is not required under this exception. In fact, it's just -- in 803(8) -- sorry -- 803(8)(A)(iii), in a civil case, factual findings from a legally authorized investigation.

OIG report from -- a different OIG report for -- from 2019 was admitted with Chris Zimmerman on May 13th. That was an OIG report specifically aimed at the DEA. Personal knowledge is not a required element here. And the face of the document, as well as the information contained within it, lays the foundation for the public records exception.

THE COURT: Well, it's pretty much self-authenticating by what it says.

MS. MCCLURE: Not just authenticating based on what it says but it, in fact, provides -- the document itself provides the foundation pursuant to 803(8).

THE COURT: I'll overrule the objection and let it

in under 803(8).
BY MS. MCCLURE:
Q. And, Ms. Colston, what is your understanding as to what this -- why this Inspector General report had been commissioned in the first place?
A. Well, it was the first major federal funding related to the opioid crisis. And that was stated in the report that that was the primary reason.
Q. Okay. And if we could look at the bottom of Page 7 of the report. You know what. I'm not giving you the right number. Hold on. It's Page 10 in the bottom left corner.
What is this chart to your understanding?
A. On Page 7?
Q. It's actually -- if you look in the little left-hand side, there's a bunch of numbers and it ends in 000010.
A. Okay. I'm sorry. Is it on Page 10?
Q. So if you're looking at the original page numbers for the document --
A. Uh-huh.
Q. -- which is the right corner, it's 7. The bottom left corner has some numbers and it's the one that ends in 10.
A. Yes.
Q. It's also on your screen.
A. Yes.
Q. Okay. What do you understand this chart to reflect?

A. It lists the 14 states that, that were part of the study and how much -- less than half of the funding was expended. So they go from the state that spent the least, or actually in this case a territory, Micronesia, and then all the way to Arizona which spent 49.4.

Q. Okay. And is West Virginia on this list?

A. It is. It is number -- it is the fourth highest, indicating that West Virginia spent 34.1 percent of its state targeted response grant within -- by the end of the two-year STR grant period.

Q. And, so, how much of the STR grant that was received by the State of West Virginia does this report indicate was unspent at the conclusion of that two-year period?

A. 65.9 percent.

Q. And, again, that two-year period was 2017 and 2018?

A. Yes.

THE COURT: Doctor -- Ms. Colston, what happens to the money if it isn't spent?

THE WITNESS: The, the state generally requests a no-cost extension. And in this actual IG report, the Substance Abuse and Mental Health Services Administration had to justify to the Office of Inspector General why they kept granting all of the no-cost extensions across the country. So that's generally what happened.

THE COURT: Okay. Thank you.

BY MS. MCCLURE:

Q. And, so, the money -- you're saying that SAMHSA did, in fact, grant West Virginia an extension to continue to try to have this money become spent; correct?

A. Yes, yes.

Q. Okay. And what was the money supposed to be used for? If we could turn to the -- back to that first page of the document. On the right-hand side and on your screen there's a gray box.

A. Oh, expand access. The purpose of the grant as stated was to expand access to evidence-based opioid use disorder treatment, to reduce unmet treatment needs, and to reduce the number of opioid-related deaths, overdose deaths.

Q. And do you recall whether this report called out the fact that West Virginia had a high level of overdose deaths?

A. Yes. The report actually expresses concern that West Virginia had such a large amount that was unspent given that it had basically the highest opioid overdose death rate in the country.

Q. And you don't know why West Virginia had not spent that two-thirds of the STR grant money; correct?

A. This document does not discuss that.

Q. Okay. And, in fact, is it your understanding from this document that there had been a formula used by SAMHSA to

allocate STR grant money; correct? Or maybe not from this document, but you understand that generally?

A. Yes, yes. The, the STR grant was supposed to be used for -- and was allocated to states with, with higher opioid overdose deaths.

Q. And are you aware as to whether West Virginia -- in addition to the formula amount that SAMHSA afforded to West Virginia, whether West Virginia, in fact, received additional funds on top of that formula amount?

A. Yes. There was a supplemental amount that was provided to the three states with, with exceptionally high opioid overdose rates. West Virginia was one of those, and it was approximately a million dollars.

Q. Okay. And that's on top of the regular?

A. On top of the regular.

Q. And, so, let's go back to our federal funding Demonstrative 5. And what does the SOR bucket there mean?

A. The state opioid response grant was kind of the replacement of the state targeted response grant. It began in 2018 and continues to this day. It is substantially larger than the amount for West Virginia and every other state.

Q. Do you mean it's substantially larger than the STR?

A. Yes, yes, ma'am.

Q. And what is the amount that you understand that West

Virginia has been receiving since 2018 pursuant to the SOR grant.

A. For 2018 and '19 they received approximately 28 million. For 2020 and 2021 they allocated $43 million to be spent over the two years.

Q. And we also have a category there called "others." What kind of grants are associated with that last bucket?

A. Well, the -- in West Virginia's case, the medication assisted treatment, prescription drug overdose grant that I talked about earlier, the MAT PDOA.

Then there is a strategic prevention framework prescription opioid grant. And then there is a preventing drug overdose grant called the PDO grant.

Those are additional grants that West Virginia has received.

Q. Okay. Moving on, then, we're going to go to our third category in blue on this screen which is Medicaid. Broadly speaking, high level, how does Medicaid work?

A. Medicaid is a federal state partnership. And both the federal government and the state government provide funding for Medicaid.

Q. And who is eligible for Medicaid?

A. Individuals who are of low income.

Q. And is Medicaid a type of insurance, health insurance?

A. It is a public health insurance program, yes.

Q. And how is that sharing determined? You said it was a federal state shared partnership.

A. The federal share is determined by the federal medical assistance percentage. And that is calculated every year. And there is an inverse relationship between income. So the lower a state's income, the higher the FMAP, which is the acronym for that, is.

Q. And, so, is that states per capita income?

A. Per capita income.

Q. And, so, lower income results in a higher level of federal reimbursement?

A. That's correct.

Q. Do you know what West Virginia's FMAP is today?

A. Today? 74.3 percent.

Q. And was that as of 2018 the 74.3 percent?

A. Yes, it was. And for 2021 it's well over 80 percent.

Q. Okay. So that means, if I understand it, that today the State of West Virginia is responsible for 20 percent of the Medicaid cost and the federal government is responsible for about 80 percent?

A. That's correct.

Q. And, so, Medicaid protects individuals; is that right?

A. Provides --

Q. Or reimbursement for individuals?

A. -- medical services to individuals, yes.

Q. Okay. And is this like a grant, or how is this different from the grants that we've been talking about on the left-hand side of the screen?

A. Generally speaking, Medicaid is the more stable -- considered to be a more stable source of, of funding. It is not grant-based. There, there isn't -- the only time periods where, where an individual may not be able to receive Medicaid is if they're -- you know, it's an income based eligibility requirement for individuals. And if their income becomes higher than the Medicaid established threshold, then they would not be -- no longer be eligible for Medicaid.

Q. Is Medicaid sometimes referred to as entitlement funding?

A. It is, yes.

Q. Okay. And, so, once you qualify, if your income does not rise above whatever the maximum is, you remain on that?

A. Pretty much on, yeah.

Q. Is it subject to any month-to-month analysis or renewal?

A. No.

Q. Okay. And, so, this was not like grants that Dr. O'Connell -- whose testimony I believe you read; correct?

A. Yes.

Q. It's not like those grants in the sense that there's a

time period --

A. Correct.

Q. -- and then they expire?

A. I believe she was talking about the category of targeted and discretionary.

Q. And is Medicaid coverage for substance use disorder, including opioid use disorder, is that again limited to just the provision of medicines or is it a broader set of services than that?

A. No. It is a broader set of services, including psychotherapeutic -- psychotherapy at any service setting; outpatient, inpatient, physician supervised. And it provides an entire continuum of substance use disorder services.

Q. So when you say entire continuum or full continuum, it's the full scope of substance use disorders that are available today --

A. Uh-huh.

Q. -- in West Virginia to patients who are diagnosed with substance use or opioid use disorder?

A. Correct.

Q. Do you know what the percent of individuals is in West Virginia covered by Medicaid?

A. I've seen ranges from 26 to 33 percent.

Q. Okay. And let's talk about changes to Medicaid, and

specifically Medicaid coverage for substance use disorder. Affordable Care Act. Did Affordable -- the Affordable Care Act change Medicaid in a way that affected the provision of substance use disorder services?

A. It did. The Affordable Care Act actually established substance use disorder services as one of the 10 essential benefits for health plans.

Q. So what's the effect of substance use disorder services now being designated as one of the 10 essential benefits -- I'm sorry -- 10 elements of essential --

A. Benefits.

Q. -- health benefits?

A. It, it kind of makes substance use disorders a more permanent part of the Affordable Care Act. In other words, they have granted that status to substance use disorders.

Q. Did the Affordable Care Act mean that more people qualified and were eligible for Medicaid?

A. It did.

Q. A couple more? Many more? What's your understanding?

A. Oh, gosh. Thousands more, thousands more.

Q. And, so, previously, prior to the Affordable Care Act, what had been the population serviced by Medicaid?

A. Medicaid serves millions of people in West Virginia, a third of, what, 1.8 million, I believe, the population. And the Affordable Care Act enhanced the number of enrollees,

right, of Medicaid enrollees, oh, gosh, 60-, 70-, 80,000.

Q. Did it change the eligibility requirement so that people became eligible for Medicaid even if they had earned more money than the pre-Affordable Care Act time period would have allowed them?

A. It did, yes, ma'am.

Q. Okay. Did the Affordable Care Act do anything for substance use services for private health insurance? I'm asking a question a little bit outside of the Medicaid world. But to your knowledge, did the Affordable Care Act do something for substance use services for people who had private insurance?

A. Yes.

Q. What did it do?

A. It -- they -- that designation as an essential health benefit covered both private insurance health plans and Medicaid.

Q. So did that mean that private insurance plans had to then cover those, --

A. Yes.

Q. -- substance use disorder as now one of the 10 essential health benefits?

A. Yes.

Q. And how is the Affordable Care Act paid for? If that's a poor question, did the federal government for a time

period pay for the expanded population that was now eligible for Medicaid?

A. The Affordable Care Act between 2014 and 2016 federal government paid 100 percent. Now in West Virginia the federal government pays 94 percent.

Q. So does that mean -- we previously talked about the 80 percent and the 20 percent for West Virginia, meaning that the federal government covered 80 percent of Medicaid.

For the expanded population, this new population that was now eligible for Medicaid, is it fair to say that the federal government pays 94 percent for that expanded population?

A. Yes.

Q. Okay. And, so, to your understanding, that changed the number of West Virginians and those in Cabell County who had coverage for substance use disorder services through Medicaid?

A. Yes.

MS. MCCLURE: And can we pull up Demonstrative 6?

BY MS. MCCLURE:

Q. Did you prepare a slide to talk a little bit about this?

A. Yes, ma'am, I did.

MS. MCCLURE: If we could pull up 6.

BY MS. MCCLURE:

Q. So tell me what this slide depicts.

A. This slide shows that based on, you know, the state data that in 2013, which was actually when the Affordable Care Act was passed, there were 5,837 individuals with opioid use disorder diagnoses in West Virginia. And this is from Medicaid, of course, --

Q. Yep.

A. -- at a cost of seven million.

Q. And then what happened in 2017 -- by 2017?

A. By 2017 the number of individuals diagnosed with opioid use disorder increased to 34,440 individuals.

Q. So was this the number of individuals diagnosed or the number of individuals who had a diagnosis and are covered by Medicaid?

A. Yes, the latter. Thank you for the clarification. And the amount of funding had increased to 84.9 million which we rounded.

Q. And do you have an understanding today as to who the largest payer in West Virginia is for buprenorphine prescriptions?

A. Yes. It's Medicaid. Medicaid pays for approximately 45 percent of buprenorphine.

Q. And what is buprenorphine?

A. Buprenorphine is used -- it's one of the three FDA approved medications to treat opioid use disorder.

Q. And has West Virginia done any forecasting as to what the number of Medicaid enrollees and the population would be for West Virginians with opioid use disorder through 2022?

A. I believe so. I believe they have. I'm sorry.

Q. I'm sorry. Did you say you do believe they have?

A. I do believe they have. I'm sorry.

Q. Okay. And what's your understanding of that West Virginia estimate of what the -- will the coverage continue to expand in your estimate?

A. Yes, West Virginia --

Q. In West Virginia's estimate.

A. West Virginia's estimate is that the number of individuals with opioid use disorder will increase.

Q. Okay. And coverage by Medicaid for individuals with opioid use disorder is predicted by West Virginia to increase as well; correct?

A. Yes.

Q. Okay. Now, we've talked a couple of times about something called an 1115 waiver. What is substance use -- sorry -- substance abuse waiver under 1115?

A. By definition, a waiver waives certain requirements, federal requirements that Medicaid imposes for, for federal reimbursement.

Q. Okay. Have you prepared a slide to talk about that?

A. Yes, I have.

MS. MCCLURE: Let's pull up Slide 7, please.

BY MS. MCCLURE:

Q. And what does this slide depict?

A. This slide talks about Medicaid's history and then the relationship between Medicaid and substance abuse over time.

Q. So when was Medicaid created?

A. 1965.

Q. And what's kind of the model? How is Medicaid referred to? It's a what kind of model?

A. Medicaid has emerged, thus the name, from a medical kind of model. So if you look on the left, physical health was really the original purpose of Medicaid in terms of mandatory benefits. And optional benefits included mental health; very few substance abuse, you know, in the '60s, '70s, and '80s.

Q. Okay.

A. And mostly inpatient-based family practice individuals and specialists were reimbursed for physical health. Because psychiatrists have always been a major part of mental health, inpatient and outpatient psychiatric therapy was provided through Medicaid.

Q. And, and in Medicaid there was -- was there a particular type of institution that was excluded from coverage or reimbursement historically for mental health facilities?

A. Yes, the state psychiatric hospitals, which at the time Medicaid was passed were primarily, if not solely, funded by state general revenue.

Q. So Medicaid said the state is responsible for paying those state mental institutions run by the state. We're not allowing reimbursement for those. Is that right?

A. That's correct.

Q. And what's that -- what was that called?

A. It's call the IMD, Institute for Mental Disease, exclusion. In other words, they're excluded from Medicaid.

Q. And how is that defined? The IMD exclusion applies to what?

A. Over the years, it has been -- it began singular, singularly being applied to mental health. But over the years, any substance abuse residential facility over 16 beds was also included.

Q. Okay. So just to draw a distinction between inpatient and residential, if I'm an individual who has need of hospital care related to either substance use or mental health, was that covered?

A. Yes.

Q. Under original Medicaid?

A. Yes.

Q. But if it's a residential treatment program, that is traditionally not covered by Medicaid?

A. That's correct.

Q. And were those residential treatment programs for substance abuse generally 28-day programs?

A. At the time, they were, yes.

Q. And were there -- were they -- did they usually -- were they usually physician-led or not historically?

A. No. In my report I talk about the history of the addiction field with limited physician involvement. That, that was primarily -- the treatment was primarily provided by counselors who were in recovery themselves. And those criteria did not meet Medicaid reimbursement.

Q. So the IMD exclusion was eventually thought to and, in fact, did cover exclusion for residential treatment services, meaning substance abuse coverage not reimbursed through Medicaid historically; correct?

A. Correct.

Q. And that doesn't mean no substance abuse services are covered by Medicaid, but the primary historical substance abuse model of residential treatment facilities was not covered by Medicaid; correct?

A. Correct.

Q. Okay. And what kinds of services would have been related to substance abuse and historically covered by Medicaid? We talked about one, that inpatient scenario where I actually require the services of a physician.

Right?

A. Outpatient -- pardon me -- outpatient services.

Q. So therapy, for example?

A. Outpatient psychotherapy, yes.

Q. By a doctor?

A. Yes. Well, physician-supervised, --

Q. Okay.

A. -- which means they have to be involved, yeah.

Q. So doctor-involved treatment?

A. That's correct.

Q. Okay. And, so, what do we call the services that Medicaid generally reimburses for historically? Are they referred to as the Medicaid state plan services?

A. Yes. Every state in the country that receives Medicaid has to have a Medicaid state plan that articulates all of the services that are required by the federal government and those optional services.

Q. Okay. So then we talked about the state plan. This is the history of how it worked. What changed?

A. The 1115 waiver was developed in 2015 through a letter basically that the centers for Medicaid and Medicare services sent to every state Medicaid director, told them about an opportunity for states to apply for an 1115 substance use disorder waiver, the primary goal of which was to expand access to treatment and provide a full continuum

of substance use disorder services that were reimbursed by Medicaid.

Q. Okay. So the 1115 of what?

A. It is a statute -- section 1115 is a statute that allows the Secretary of the United States Department of Health and Human Services to, to approve a state implementing an innovation. It could be an innovation in service delivery, for example, managed care, let's say, instead of fee for service reimbursement.

So it allows the Secretary to say, okay, I'm going to waive this requirement here and let you demonstrate whether this works over a five-year period of time.

Q. Okay. So this 1115 waiver, a letter went out from CMS, Center for Medicaid Services; right?

A. Yes.

Q. To each state?

A. Yes.

Q. So if we have, going back to our chart, we have IMD being excluded from Medicaid, would this waiver mean that then the IMD exclusion would not apply if the state got approval from CMS for the activity sought by its waiver?

A. Yes. If the state requests it in their waiver application, CMS has approved it all over the country. So they've approved the exclusion of the IMD requirement.

Q. So it's a waiver of the exclusion --

A. I know.

Q. -- meaning that then it's covered; right?

A. Yes.

Q. Okay. And if we look at our chart here, if we take the lines there, if we move to the right, is this now what Medicaid looks like with an 1115 waiver with then Medicaid covering that substance abuse for residential treatment?

A. Yes, --

Q. Okay.

A. -- regardless of its size.

Q. And we've gotten rid of that dark black line?

A. Yes, we have.

Q. It expanded coverage; right?

A. Yes.

Q. And you've talked about a time limit for the 1115 waiver. What is that time period?

A. Five years.

Q. And I believe you said it was a, a research grant; is that right?

A. It's called a Research and Demonstration grant. So the states have an opportunity with the substance use disorder 1115 waiver to again demonstrate that there is something they are doing, for example, providing a full continuum when they haven't had one before.

Q. A full continuum of what?

A. Of substance abuse services to see if more people are served, if people have better treatment outcomes, that kind of thing. It varies by waiver and by state.

Q. Okay. So is the purpose to try to improve health outcomes and healthcare?

A. That is the bottom line, yes.

Q. Okay. And can that five-year period be extended for an 1115 waiver?

A. Yes, it can.

Q. How do you know that?

A. I beg your pardon?

Q. How do you know that?

A. Well, I probably have researched every one of them in preparation for my work with Alaska, and I've certainly read West Virginia's several times, and all of the correspondence which is available publicly. So, yes, I've read every --

Q. So you've read about 1115 waivers. But my question is can that five-year period, can states apply for an extension?

A. Yes, they can and they do.

Q. And what happens if the services during that five-year research grant period -- if the state at the end of it is able to demonstrate that it works, what then?

A. The federal government would probably begin negotiations to try to get as many of those services in the

state plan as they could.

Q. And if the services are then included in a state plan, these additional substance use disorder services, would that also then be subject to another five-year period or are they just in the plan?

A. They're just in the plan.

Q. And is that more stable and sustainable than just the five-year period?

A. It certainly is.

Q. Okay. And did you review -- you've already said that. Did West Virginia apply for an 1115 waiver?

A. Yes, they did in 2016.

Q. And do you know if they received approval for that 1115 waiver?

A. They did. They received approval in 2017 and began service delivery in January of 2018.

Q. So that's a period of five years through, through the end of 2022?

A. Yes.

Q. And have you reviewed what Medicaid services are now available in West Virginia for substance use disorder?

A. I have.

Q. Okay. And did you prepare a demonstrative about those services?

A. I did.

Q. Okay.

MS. MCCLURE: If we could pull that up, that's Demonstratives 9 and 10.

BY MS. MCCLURE:

Q. So, Ms. Colston, does this -- what's the column on the left mean there, that ASAM column?

A. That column is the level of care identified by the American Society of Addiction Medicine. They are considered to be the industry standard for establishing levels of care and staffing and programmatic requirements.

Q. Okay. And, so, the American Society of Addiction Medicine, ASAM, is like a universal standard?

A. It is.

Q. Okay.

A. Yes.

Q. And that -- the middle column where it says "benefit," where is that wording taken from?

A. Usually it's a Medicaid term. Medicaid provides benefit to benefit -- it's a service. It is a benefit to individuals eligible for Medicaid.

Q. And does the description of the benefit match up with that ASAM for each of these levels?

A. It does.

Q. And on the right each of those entries says state plan or 1115. What does that mean?

A. That means that either the benefit is allowed under the state plan or it is a benefit that was established by the 1115 waiver.

Q. And, so, this represents, then, the spectrum of SUD, substance use disorder, services available in West Virginia today; correct?

A. Yes, it represents the continuum of substance use disorder services.

Q. You've predicted my next question which is does this represent the full continuum then of SUD services available to Medicaid enrollees in West Virginia today?

A. Yes.

Q. From 2018 forward?

A. Yes.

Q. And for the record, Ms. Colston, we're going to please review each of the benefits. I don't think we need to read in the ASAM number. But if you could -- the benefit in the first line, SBIRT, what is that?

A. That is screening, brief intervention, referral and treatment.

Q. And in West Virginia is that covered by Medicaid?

A. Yes, it's covered by the state plan.

Q. And how about peer recovery support services? Is that covered by Medicaid in West Virginia?

A. It is by the 1115 waiver.

Q. And outpatient services?

A. State plan.

Q. Intensive outpatient?

A. State plan.

Q. Partial hospitalization?

A. State plan.

Q. And, again, if we want to know what exactly the benefits are here for each of these levels, that would depend on the West Virginia contract with the federal government; is that right?

A. Yes.

Q. For benefits?

A. Yes.

Q. And I just wrote on this. Apologies. Clinical managed low intensity residential, is that covered in West Virginia?

A. Yes, by the 1115.

Q. How about clinically managed population specific high intensity residential?

A. 1115.

Q. And clinically managed high intensity residential?

A. 1115.

Q. Those last three that we've discussed, is that a significant change brought about by the 1115 waiver because historically residential substance abuse would not have been covered?

A. Yes.

Q. And medically monitored intensive inpatient?

A. State plan.

Q. Medically managed intensive inpatient services?

A. State plan.

Q. Ambulatory withdrawal management services?

A. State plan.

Q. Ambulatory withdrawal management services Level II?

A. Yeah, state plan.

Q. Clinically managed residential withdrawal management services?

A. That's the 1115.

Q. Okay. And medically managed -- I'm sorry. Medically monitored inpatient withdrawal management services?

A. State plan.

Q. Opioid treatment program services?

A. That's for methadone services and that's the 1115 waiver.

Q. Okay. Office-based opioid treatment?

A. State plan.

Q. Targeted case management?

A. State plan.

Q. Transportation?

A. 1115.

Q. And naloxone administration services?

A. State plan.

Q. Let's look back at that transportation. Is there any other federal funding for transportation that exists in addition to the 1115 waiver for patients who need transportation for substance use disorder treatment?

A. Yes.

Q. What is that funding?

A. The state opioid response grant.

Q. So that's the SOR grants that we previously discussed?

A. Yes, it is.

Q. And perhaps given everything we've talked about today, this is maybe a question with an obvious answer, Ms. Colston, but do Cabell County and the City of Huntington pay for Medicaid coverage for Medicaid enrollees?

A. No.

Q. Okay. Let's go back to our Demonstrative 5 and we're going to talk about the last bucket on that demonstrative, Medicare.

And is Medicare another source of federal funding that can cover or reimburse for substance use disorder services?

A. Yes, it is.

Q. And when I say substance use disorder services, is that a broader term than opioid use disorder services?

A. Yes, it is. Opioid use disorder services are a subset, if you will, of the substance use disorder services.

Q. Okay. And at a very high level, how do Medicaid and Medicare differ?

A. Medicare is based on an individual's disability or age. So those of us over age 65 are automatically eligible for Medicare. And then any individual 18 years or older can qualify by virtue of their disability.

Q. And is this like Medicaid in that it is not like a grant in its entitlement funding?

A. That's correct.

Q. Has Medicare coverage for SUD expanded, substance use disorder expanded over the past 10 years?

A. Yes.

Q. And do you know the percentage of people covered by Medicare in West Virginia approximately?

A. I believe it's 26 percent.

Q. Did you discuss that in your report?

A. I did.

Q. Okay.

A. I did. I'm sorry. I just can't remember the exact number.

Q. Would looking at your report refresh your recollection?

A. Yes, it would. Yes, thank you.

MR. FARRELL: Judge, I don't mind if she just verbally reminds her.

THE WITNESS: Yeah.

BY MS. MCCLURE:

Q. Does your report indicate that it's about 20 percent?

A. Yes, it does.

Q. Thank you.

A. Thank you.

MS. MCCLURE: Thank you, Mr. Farrell.

BY MS. MCCLURE:

Q. Do you know what -- so there's two ways to qualify for Medicare: Age, disability status?

A. Correct.

Q. Do you know what percentage of people in West Virginia qualify for Medicare due to that disability status?

A. Well, I know that West Virginia has the highest rate of, of disability. That might be the 26 percent figure. But they do have the highest disability rate in the country, West Virginia does.

Q. And did you prepare a demonstrative showing what Medicare covers for opioid use disorder and substance use disorder?

A. Yes.

MS. MCCLURE: Okay. If we could pull up Demonstrative 11.

THE WITNESS: Uh-huh.

BY MS. MCCLURE:

Q. And so, Ms. Colston, does this slide indicate that Medicare covers both inpatient and outpatient programs for substance use disorder?

A. Yes, it does.

Q. And medications used in treatment but not methadone?

A. Uh-huh.

Q. Correct?

A. Uh-huh.

Q. She can't --

A. Yes, yes.

Q. And -- but methadone we've seen is covered in other ways in West Virginia; right?

A. Yes.

Q. And partial hospitalization covered by Medicare?

A. Yes.

Q. And as of January 1st, 2020, this opioid treatment program under Part B does cover that methadone; correct?

A. Yes, that's correct.

Q. And counseling and therapy; right?

A. Psychotherapy, yes.

Q. And do all of those categories hold true for Medicare enrollees in Huntington and Cabell?

A. Yes.

Q. And is there an OTP, or an opioid treatment program in Huntington today?

A. Yes, there is.

Q. Do you know what that's called?

A. Comprehensive -- Huntington Comprehensive Treatment Center.

Q. And historically from 2018 to today, has the number of enrollees in Medicare been expanding in West Virginia?

A. Yes.

Q. Okay. And, again, this may be a question with an obvious answer, but do Cabell and Huntington pay for Medicare coverage for the city and county Medicare enrollees?

A. No. It's a federally funded program.

Q. Okay. And I believe you've looked at other kinds of coverage like private health insurance. You understand that there are individuals in Huntington/Cabell who have private health insurance, not Medicare, not Medicaid, not these federal programs. Right?

A. Yes.

Q. And do you know what percentage of the West Virginia population that has some healthcare insurance coverage?

A. I believe it's 94 percent.

Q. And do you understand that that number is the same or different or about, or higher in Cabell/Huntington?

A. I think it's about the same in Cabell/Huntington.

Q. Okay. So we've been talking a lot --

MS. MCCLURE: We can take that slide down.

BY MS. MCCLURE:

Q. We've been talking about federal funding for substance use and abuse. Is there also state funding in West Virginia for substance use disorder?

A. Yes, there is.

MS. MCCLURE: And, Your Honor, I'm about -- I'm about to move into a new area and probably have about, about half an hour remaining of testimony. This would be a good time, given the shift, to do a break if that would be okay with the Court.

THE COURT: Are we going to be able to finish Ms. Colston?

MS. MCCLURE: I do believe we will be able to. It, of course -- I certainly will be able to. I believe it depends on the scope of cross. So I would ask Mr. Farrell to advise time period which, of course, I haven't finished the direct yet. But I will represent that I have about half an hour remaining for Ms. Colston.

THE COURT: Let me ask the plaintiffs how long you expect.

MS. KEARSE: Your Honor, I would anticipate we could get our cross, if the two of us are doing cross, by the end of the day.

THE COURT: All right.

I'm going to ask you to come back at 2:00, Ms. Colston, and we'll resume then. And we'll be in recess until 2:00.

MS. MCCLURE: Thank you, Your Honor.

(Recess taken at 11:58 a.m.)

THE COURT: Do we have a witness?

THE WITNESS: I'm here.

THE COURT: Oh. You can resume the witness stand, Ms. Colston.

MS. MCCLURE: May I continue, Your Honor?

THE COURT: Yes, please.

BY MS. MCCLURE:

Q. Ms. Colston, shifting to a different topic area, did you prepare a slide that discusses some data on recent overdose deaths in Cabell and Huntington from the DHHR website?

A. Yes.

Q. Okay.

MS. MCCLURE: Could we put up that demonstrative, please?

BY MS. MCCLURE:

Q. Can you tell us, what does this demonstrative depict?

A. This depicts the emerging threat of fatal methamphetamine overdoses in West Virginia.

Q. And what does this chart measure? It's hard to see, but the chart on the right under the title you read,

Emerging Threat Fatal Methamphetamine Overdoses, those four different color schemes, can you just walk through for the record what each of them shows, the colors, what each of them are?

A. Yes. The -- I'll start with the bottom, blue. That is methamphetamine and heroin.

Q. Okay. And the next, yellow?

A. The one on top is methamphetamine and fentanyl. Next is methamphetamine and any opioid. That's the pink. And then, I guess what I would call lavender is methamphetamine.

Q. And that last one is methamphetamine alone?

A. Yes.

Q. And is that the highest one on that chart?

A. It is.

Q. Okay. And what does this generally depict about methamphetamine and overdoses?

A. That between the first quarter of 2015 and the fourth quarter of 2020, it substantially increased with peaks in the third quarter of 2018 and the first and third quarters of 2020. Just keeps going up.

Q. Okay. And so, based on your review of the materials, what substances are the most common reasons for drug overdoses in Cabell County?

A. Are you talking about the class of drugs?

Q. Correct.

A. Psychostimulant.

Oh, sorry.

MR. ACKERMAN: Objection, Your Honor. I thought at the beginning of this testimony we were talking about we weren't -- this witness was not offering any opinions related to causation and these questions appear to be going directly to causation issues.

MS. MCCLURE: Your Honor, Ms. Colston was qualified as an expert in trends regarding Substance Use Disorder.

THE COURT: Yeah, overruled. Overruled. She can answer.

MS. MCCLURE: Thank you.

BY MS. MCCLURE:

Q. Do you need the question repeated?

A. Yes, please.

Q. Okay. And based on your review of the materials, what do you understand is the most common drugs involved in overdoses in Cabell County?

A. Psychostimulants.

Q. And just to be clear, a psychostimulant is what?

A. Includes drugs like methamphetamines and cocaine.

Q. And is opioid a psychostimulant?

A. No, ma'am.

Q. Ms. Colston, in your opinion today, is there a

prescription opioid crisis in Cabell County?
A. No. There's -- there is a psychostimulant problem, specifically methamphetamine, today in Cabell County.
Q. But it's your opinion that there's not a prescription opioid crisis today?
A. That's correct.
Q. And what information do you have or have you seen that supports that conclusion that's your opinion?
A. As I mentioned in my report, the dispensing rate, the MME dosage, the number of practitioners who are issuing prescription opioids, have all gone down and that's what I'm basing it on.
Q. So, prescribing has decreased?
A. Prescribing has decreased.
Q. And are you aware of Dr. Alexander's testimony regarding a decrease in drug overdose death rates between 2016 and 2019?
A. Yes.
Q. Okay. Do you recall what that decrease was approximately?
A. I do not. Sorry.
Q. How would you characterize what the current problem is broadly today in Cabell County?
A. I believe it is a Substance Use Disorder crisis basically.

Q. Okay. And if we could --

MS. MCCLURE: Your Honor, may I approach with a document?

THE COURT: Yes.

MS. MCCLURE: This is DEF-WV-696. If I recall --

MR. FARRELL: Judge, before we get started, just to save time, we object to this witness being the vehicle for this document. This document was written by somebody and sent to someone else, neither of which is the party sitting in the stand today.

MS. MCCLURE: So, Your Honor, Ms. Colston is here testifying as an expert today. Pursuant to Rule 703 she is entitled to rely on materials that have not been admitted into the record. There's no question that experts are entitled to rely on hearsay.

THE COURT: Well, that's right. She relied upon it in forming her opinion and I think she can refer to it, but that doesn't make it admissible.

MS. MCCLURE: And to be clear, I'm not moving admission of this document today. It's forming the basis. It's going to be used in her testimony as for the information.

BY MS. MCCLURE:

Q. Ms. Colston, have you seen this letter previously?

A. Yes, I have.

Q. And did you rely on it in forming your opinions?
A. Yes, I did. Yes, I did.
Q. What is the date of this letter?
A. October 18th, 2019.
Q. And what do you understand this letter to be?
A. The letter appears to be in response to several questions by the Chairman of the Committee on Energy and Commerce.
Q. Can you turn to the final -- actually, let me tell you the correct page. The page that has a signature on it, which if you look in those little numbers in the left-hand corner at the very bottom, it ends in 00013.
A. Yes, I see that.
Q. Who signs this letter?
A. Commissioner Christina R. Mullins.
Q. And what is she a commissioner of?
A. DHHR's Bureau for Behavioral Health.
Q. And do you have an understanding as to what that means for Christina Mullins' responsibilities in West Virginia for distribution of federal funds?
A. Well, she has a similar role that I had in Florida. She is the -- she has the responsibility for federal substance abuse, and mental health funds, for that matter.
Q. Is it your understanding that at the time she authored this letter she was, in fact, the single state authority for

West Virginia?

A. Yes. That's my understanding.

Q. And can you explain your understanding of why she's writing this letter?

MR. FARRELL: Objection, Your Honor.

BY MS. MCCLURE:

Q. And I'll direct --

MR. FARRELL: Objection, Your Honor.

MS. MCCLURE: Okay.

MR. FARRELL: Calls for speculation.

MS. MCCLURE: I will rephrase, Your Honor.

If you could pull up the letter, Richie, and publish the first page, the very first paragraph at the top.

MR. FARRELL: Objection, Your Honor. She can rely upon the information in here, but I don't think it's permissible for her just to start reading into the record what the letter says.

THE COURT: Well, I think that's right. You can use it as a basis to question her, Ms. McClure, but I think I'll sustain the objection to her reading the letter into the record.

BY MS. MCCLURE:

Q. Ms. Colston, do you have an understanding that this letter is responding to a house -- a congressional inquiry to the single state authority for West Virginia?

MR. ACKERMAN: Objection. Leading.

THE COURT: Sustained.

MS. MCCLURE: A moment, Your Honor.

(Pause)

BY MS. MCCLURE:

Q. Have you seen letters like this before in your capacity either in Florida or in your consulting capacity where states respond to congressional inquiries?

A. Yes.

Q. What is your understanding of the nature of the congressional inquiry to which Ms. Mullins was responding in her capacity as the single state authority?

A. It appears that Congressman Pallone is asking her about how federal opioid funds are used, distributed, deployed in West Virginia.

Q. And is it your understanding that Commissioner Mullins was writing in her official capacity at the direction of the Cabinet Secretary in West Virginia?

MR. FARRELL: Objection, Your Honor. I'm not quite sure the basis is in this letter for what the witness just said.

I'll remind the Court that this is one of the documents that gives rise to the Energy and Commerce Report which you have excluded and it says on the very first paragraph that this letter was sent by one person to another requesting

information regarding West Virginia's response to the opioid crisis. I'm not quite sure what -- where the basis for the testimony is coming from.

MS. MCCLURE: Your Honor, the addressee of the letter, the person to whom it is addressed, is not relevant for inquiry, other than the fact it was a congressional inquiry. And Ms. Mullins, in her capacity as the single state authority for West Virginia, is providing a statement to Congress on the fact that opioid money remained unspent in -- from -- that West Virginia received and was unable to spend.

There's not a problem with the witness's answer that she just gave, I think, which is what his request specifically relates to, is the answer that she provided as to what the letter reveals, and that Ms. Colston relied on this letter in forming her opinion that West Virginia did not spend a significant portion of its federal funds.

THE COURT: Well, you can -- you can ask her that, but I'm not going to let you go into the letter any further than you have, Ms. McClure. I think the objection is well taken and you can get around it if you can.

BY MS. MCCLURE:

Q. Ms. Colston, why did you rely on this letter?

A. Because it indicated that West Virginia -- it documented that West Virginia did not spend all of its

federal funding.

Q. Did Ms. Mullins make any statements about positive impacts in this letter that --

MR. FARRELL: Objection, Your Honor. Same basis. She can ask the witness whether or not West Virginia spent the money and how she knows it, but not read or recite from the letter.

THE COURT: Sustained. Sustained. I'll sustain the objection.

BY MS. MCCLURE:

Q. Ms. Colston, do you have an understanding as to whether West Virginia spent the significant federal funding it received between 2016 and 2019?

A. Yes. According to the information in this letter, they did not spend all of the money that they --

Q. Do you have an understanding as to -- I'm sorry. I didn't mean to cut you off.

A. That's all right.

Q. Do you have an understanding as to how much money approximately West Virginia had been afforded by federal funding as reflected?

A. I believe it was $147 million. And then Ms. Mullins -- I'm trying to remember the percentage. I probably won't, Your Honor, but it was around $65 or $66 million had been allocated.

Q. And do you have an understanding as to if those numbers are correct that you've just offered, what that amount of unspent federal spending was for opioids out of the $148 million?

A. Probably about $80 million.

Q. Did this letter also inform your opinion as to what West Virginia had done with the money that it had spent, the $65 million out of the $148 million?

A. Yes. I believe --

Q. And is your understanding that West Virginia had deployed some of that money?

A. Yes.

Q. And do you have an understanding as to whether Ms. Mullins characterized that money as helpful --

MR. FARRELL: Objection.

BY MS. MCCLURE:

Q. -- to West Virginia's response?

MR. FARRELL: Objection, Your Honor.

THE COURT: I'll sustain the objection, Ms. McClure.

BY MS. MCCLURE:

Q. Ms. Colston, do you have an understanding as to how Ms. Mullins characterized the money that had been spent by West Virginia pursuant to the SAPP grant and other grants?

MR. FARRELL: Objection.

THE COURT: Sustained. Sustained.

BY MS. MCCLURE:

Q. Ms. Colston, did you find Ms. Mullins' letter -- I'm sorry. Let me rephrase.

Ms. Colston, did you rely on Ms. Mullins' letter in forming your opinions here today?

A. Yes.

Q. Is that -- does that testimony that you relied on, that letter, extend to the impact of the funding that West Virginia had received?

A. Yes.

Q. And what opinions or conclusions were you able to draw in relying on the letter from Ms. Mullins about the impact of the funding that West Virginia received?

A. Well, she -- she basically says for the first --

MR. FARRELL: Objection, Your Honor.

THE COURT: Sustained.

BY MS. MCCLURE:

Q. So, without characterizing what Ms. Mullins said, can you explain how this letter impacted your understanding and then formed the basis for your reliance opinions here today?

A. My understanding is that the money was essential to building a treatment infrastructure for West Virginia and increasing access to Opioid Use Disorder services.

Q. Now, you testified a minute ago regarding the

psychostimulant crisis you believed exists in Cabell County. Did this letter form any basis for your understanding of that crisis?

A. Yes, it did.

Q. In what way?

A. Because Commissioner Mullins was basically advising --

MR. FARRELL: Objection.

THE COURT: Yes. This --

MS. MCCLURE: Okay.

THE COURT: Sustained.

BY MS. MCCLURE:

Q. Ms. Colston, did you review Dr. Alexander's expert report and trial testimony in this matter?

A. Yes, I did.

Q. And at a high level, do you have an understanding as to Dr. Alexander's goal or purpose was in this matter, what he was asked to do?

A. Dr. Alexander was asked to provide the State with a plan to mitigate the opioid crisis.

Q. And do you have an opinion as to Dr. Alexander's plan in terms of abating the opioid crisis?

A. I believe the plan -- excuse me -- lacks important information about existing treatment capacity and prevention capacity in Cabell County and the City of Huntington, West Virginia.

Q. Have you conducted needs assessments previously?

A. I have reviewed needs assessments. I do not recall conducting a needs assessment.

Q. Have you reviewed the needs assessment to determine whether those assessments are performed with adequate methodology and to achieve the purpose for which they're drafted?

A. Yes, I have.

Q. And what is the purpose of a needs assessment?

A. A needs assessment is a -- is a systematic process to basically determine whether existing capacity meets an identified need. So, a needs assessment would include looking -- for substance abuse would include looking at prevalence, doing an inventory of existing services and programs, and their capacity, and their funding, and their utilization rate, and -- and identifying the gaps and making recommendations to move forward to address the need.

Q. And in your opinion, based on your review of Dr. Alexander's plan, did you see him offer specifics about existing community capacity?

A. Dr. Alexander mentioned several programs, but he did not discuss capacity numbers.

Q. Okay. Are you familiar with programs and services in Huntington that provide Substance Use Disorder, for example, to women?

A. Yes, I am.

Q. Could you provide any information about those?

A. Yes. Project Hope at Marshall University provides services to women. PROACT, it's an outpatient group, provides services to women. Hoops Family Services provides support services to women whose children are in the Neonatal Intensive Care Unit.

There is -- there are residential programs at Prestera that are women-specific. There is Recovery Point's HER House. There are Oxford recovery houses that are specific to women. And I'm missing some, I'm sure.

Q. And did you see Dr. Alexander address the capacity, meaning the utilization rate, or the capacity, the availability of treatment for those particular facilities?

A. No.

Q. Did Dr. Alexander provide information about the number of people served on a yearly basis?

A. No.

Q. How about waiting list information and data and evidence about waiting lists?

A. No.

Q. And would that information be, in your experience, important to have to evaluate the need in a community?

A. I don't see how you can evaluate need in a community without it.

Q. Okay. And the programs and services you just listed were ones for women. Is it your understanding that there are other programs and services for men, for children, for families in the Huntington-Cabell community?

A. Yes. And other special populations, such as justice-involved populations.

Q. And did you see any information detail evidence about the number of providers by a specific type of service?

A. No.

Q. Okay. Number of persons served per year?

A. No.

Q. For any of the programs and services?

A. No.

Q. Utilization rate?

A. No.

Q. Did you see information about staff -- staff members per service, the ratio of staff members?

A. No.

Q. Did you see information about payers and how programs are funded?

A. No, ma'am.

Q. Medicaid claims data?

A. No.

Q. And would this information that we've just listed off about providers' utilization, et cetera, be important to

conduct a needs analysis?

A. Yes.

Q. Is it your understanding that this type of needs assessment information -- and I'll use needs assessment information to refer broadly to all of those capacity utilization payers, numbers served, et cetera. Do you understand that?

A. Yes, ma'am.

Q. Okay. Is that type of needs assessment information available, to your knowledge, in this record in this case?

A. No.

Q. And during your time as a federal contractor for SAMHSA, your responsibility included reviewing needs assessments, correct?

A. Yeah. The -- yes. The needs assessment was a requirement of that.

Q. And your time at SAMHSA as a federal contractor required evaluating needs assessments to see if they were sufficient, demonstrated a need?

A. Yes.

Q. And, to your knowledge, is there a needs assessment for Cabell County and the City of Huntington related to Opioid Use Disorder in this record?

A. No.

Q. Could you today conduct a needs assessment based on the

information in this record if you wanted to?

A. No.

Q. Is your opinion that the record contains evidence that there is a full continuum of SUD services and OUD services available to the Huntington-Cabell County community?

A. The record?

Q. Is it your opinion -- let me rephrase that. Have you seen services and programs that cover the full spectrum of Substance Use Disorder services in Cabell and Huntington today?

A. Yes.

Q. And we're not going to go through in detail each of those programs and services, but is it your understanding that the majority or any of the programs and services that you've seen are funded by Huntington-Cabell County?

A. I believe maybe one is funded by Cabell County and the City of Huntington.

Q. And you're familiar with Dr. Alexander's report?

A. Yes.

Q. Did you see a list of individuals with who he had spoken?

A. I did.

Q. And is it your -- did you see any specific information, evidence or data from those individuals that then later informed his opinion about what he claimed was needed?

A. No, I didn't.

Q. Is it your opinion today that Dr. Alexander's plan does not account for existing programs and services in Cabell-Huntington, their capacity, and how they are funded?

A. Correct. That's correct.

MS. MCCLURE: May I have a moment, Your Honor?

THE COURT: Yes.

(Pause)

MS. MCCLURE: Thank you, Your Honor. No further questions at this time.

THE COURT: All right. You may cross examine.

CROSS EXAMINATION

BY MR. FARRELL:

Q. Good afternoon. My name is Paul Farrell. It's nice to meet you.

A. Nice to meet you.

Q. I have a couple of questions for you. I've read your report and I've listened to your testimony today. And so, I'd like to see if I can use my words to fairly encapsulate the scope of your testimony.

Is it fair to say that your -- your testimony is that the federal and state governments have spent money abating the opioid epidemic?

A. It's my opinion that the federal and state monies have provided funding to -- to respond to the opioid crisis.

Q. Okay. And you cite in your report that I believe West Virginia's 2017 Medicaid expenditure for the OUD population totalled over $338 million dollars; is that right?

A. Yes. That is a report by Minot Health.

Q. And the Medicaid population is about 25 percent of the State's population, you said?

A. Correct.

Q. So, if you multiply that out, if 25 percent of the population is -- the state Medicaid is $338 million, would it be fair to say that the OUD population, there's an expenditure of about a billion dollars a year in West Virginia?

A. No. I don't believe that. I don't believe so.

Q. Okay. So then, let's just stick with the premise. You are saying that in 2017, West Virginia's Medicaid expenditure was $338 million dollars?

A. Well, you have to clarify, sir, what that's for. The $338 million dollars was for physical and behavioral health and Opioid Use Disorder and Substance Use Disorder services for individuals who were diagnosed with Opioid Use Disorder. It's a little more specific.

Q. Yes, ma'am. And you've also believed that spending money on evidence based healthcare services has been effective in abating the opioid epidemic?

A. I believe that evidence based practices are essential

to improving health and essential to being able to respond to drug crises, yes.

Q. And so, specifically, expending money on evidence based practices is necessary to abate the opioid epidemic; true?

MS. MCCLURE: Objection, Your Honor. Asked and answered.

THE WITNESS: I believe I've already --

THE COURT: Overruled.

You can answer it if you can, Ms. Colston.

THE WITNESS: Okay, thank you.

It's a little more specific a question than -- than I think is actually the reality. The reality is, evidence based practices have -- their very nature is there's some research behind the evidence based practice.

If you're referring to medication assisted treatment for Opioid Use Disorders, then I would say medication assisted treatment, Buprenorphine, Methadone, Naltrexone, have scientific evidence of their effectiveness for individuals with Opioid Use Disorder.

BY MR. FARRELL:

Q. And so, you would support spending money on those practices to abate the opioid epidemic?

MS. MCCLURE: Objection, Your Honor, to the continued use of the word abatement.

THE COURT: She said she doesn't agree there is an

epidemic.

MR. FARRELL: Oh.

THE COURT: Isn't that right?

THE WITNESS: That's correct.

MR. FARRELL: Well, let's back up.

BY MR. FARRELL:

Q. Is there currently an opioid epidemic in the United States?

A. I believe there is a broader Substance Use Disorder problem in the United States and that it shifts from drug to drug. So, today it may be psychostimulants, which it appears to be, as opposed to opioids.

And -- and to clarify, today, many individuals and most individuals use more than one substance. So -- so, pointing a finger at any one of those substances is not quite what I think is accurate.

Q. Okay. So, let me see if I can tease this out a little bit. You spent your professional career approving grants for substance abuse, correct?

A. Approving grants? I have spent my years doing a lot with grants relating to substance abuse, monitoring them, approving them, utilizing them as a provider.

Q. So, the answer is yes?

A. The answer is yes.

Q. Okay. So --

A. A little broader an answer to that question.

Q. In that time frame --

MS. MCCLURE: Your Honor, I would just request that the witness be permitted to finish her answer prior to Mr. Farrell asking questions.

THE COURT: Yeah. You're a little too eager to get on with it here, Mr. Farrell. Give her a chance to explain her answer.

MR. FARRELL: Well, it is the last witness on the last day of the last trial. So, yes, I am eager.

BY MR. FARRELL:

Q. But I apologize for over-speaking you.

A. That's all right.

Q. So, let's back up. Do you acknowledge that at some point there have been declarations that the United States is suffering from an opioid epidemic?

A. Yes.

Q. And you're aware that there -- that there is a current body of medical literature that supports the idea that there is presently an opioid epidemic in the United States?

A. I'm not aware of current research that indicates we are still experiencing an epidemic. I am aware of research that indicates it's a polysubstance abuse crisis that we suffer and a broad Substance Use Disorder.

Q. So, when you say poly, poly is a fancy word for many,

correct?

A. Yes, it is.

Q. And one of those many would be opioids?

A. Correct. And psychostimulants.

Q. Okay, psychostimulants. But this case is about opioids. So, what I'm asking you is, is whether or not you believe that there is a significant public health crisis in Huntington, Cabell County, West Virginia which includes the use and abuse of opioids?

A. It includes the use and abuse of many drugs, sir.

Q. Yes. I'm aware of your testimony and I'm asking you whether or not --

A. Yes. Opioids would be one of those many.

Q. Yes, thank you.

A. If that's the question.

Q. Thank you.

Now, you believe that money is needed in the future to provide healthcare services to those suffering from Substance Use Disorder to abate the epidemic; true?

A. I'm sorry. That was a very long question.

MS. MCCLURE: Your Honor, I would just lodge a continuing objection to the continued use of the word abatement, as opposed -- she has corrected every question --

THE COURT: Is that your objection, too, Ms. Hardin?

MS. HARDIN: Yes, sir.

MR. FARRELL: Well, to be fair, Judge, I believe the transcript -- the witness was literally asked and used the word abatement during direct testimony, but I'd be willing to substitute the word abatement for some other synonym if that helps.

THE COURT: Well, we've talked a lot about abatement for weeks. I'm going to let you go ahead and ask her about it using the word abatement.

MR. FARRELL: Okay.

THE COURT: And we'll -- but give her a chance to explain her answer.

MR. FARRELL: Yes, sir.

THE COURT: She may not agree with you.

BY MR. FARRELL:

Q. So, and I believe that in Footnote 3 on Page 3 of your report you make reference to the legal term abatement, which isn't something in your field; is that right?

A. Correct.

Q. And, instead --

MS. MCCLURE: Your Honor, I request that if Mr. Farrell is going to inquire about things that she said in her report that he provide her with a copy of her -- of her report.

THE COURT: Do you have a copy of her report you

could give her, Mr. Farrell?

MR. FARRELL: I do, but I don't really intend to spend any time on it.

THE COURT: Okay. If you need to refer to your report, tell us, and we'll get it for you. Otherwise, we're going to let him go ahead.

THE WITNESS: Okay, thank you.

BY MR. FARRELL:

Q. I think what you had said was that you would rather call them response programs; is that fair?

A. Yes.

Q. All right. So, I'm going to start using response programs instead.

A. Okay.

Q. Do you believe that spending money on evidence based response programs is effective in abating whatever opioid epidemic presently exists in Huntington-Cabell County, West Virginia?

A. I believe that response programs which address any drug being abused in Cabell County should use evidence based practices. It is not specific to opioid. Evidence based practices are essential for individuals to improve.

Q. And so, you believe -- do you believe that more money in the future is needed to fund these programs?

A. What programs?

Q. The programs that we've been talking about all morning?

A. Response programs?

Q. Yes.

A. I'm not sure I do. I think you have to do a needs assessment and understand what the existing capacity is and determine where your gaps in services are. So, I guess I would not agree with that statement just wholesale.

You've got to know what you have before you allocate resources. How do you -- how do you allocate resources without knowing what is currently in place and whether they're full, or whether they're empty, or whether they have a waiting list, for example? Does that make sense?

Q. Yes, ma'am.

A. All righty.

Q. So, let me ask you this. Will you agree that there currently exists a substance abuse epidemic in the United States?

A. In the United States?

Q. Yes.

A. An epidemic?

Q. Yes.

A. No. I think a series of crises that shift from drug to drug.

Q. Is there a substance use epidemic in West Virginia presently?

A. I think that there is a substance use -- a series of crises in West Virginia that have occurred over many years, actually.

Q. Yes, ma'am. And what about in Huntington, Cabell County, West Virginia, is there a substance use crisis going on in Huntington-Cabell county, West Virginia?

A. Yes, I believe there is.

Q. And is -- and opioids are a component of that substance use crisis, correct?

A. One of several, yes.

Q. Very good. Do you believe that the substance use crisis in Huntington-Cabell County, West Virginia significantly interferes with the public health?

A. I think it -- oh.

MS. HARDIN: I'm just going to note an objection for the record, Your Honor, to the extent that that calls for a legal conclusion.

THE COURT: Overruled. I don't think it does.

THE WITNESS: Could you repeat the question? I'm sorry.

MR. FARRELL: Yes.

BY MR. FARRELL:

Q. Do you believe that the opioid crisis in Huntington-Cabell County, West Virginia significantly interferes with the public health?

A. Well, I -- I think I've stated several times I don't believe there is a -- a single drug crisis, whether it's opioid or anything else in Cabell County. I believe there are several drugs that are being used and it's more a polysubstance issue. There are several drugs that are being used and, frankly, being used -- if you look at the overdose data that we provided earlier, it's clear. It's illicit fentanyl that is the primary opioid that is the issue now. It is also methamphetamine. It is also psych -- other psychostimulants. So --

Q. So, let me rephrase it. Do you believe that the polysubstance abuse that's going on in Huntington-Cabell County significantly interferes with the public health?

A. I believe it interferes with the public health, absolutely.

Q. Now, at some point in time, do you believe there was an opioid epidemic in the United States?

A. I believe -- as I mentioned earlier -- I believe I've answered this. I believe that there have been a series of shifting drug crises throughout this country for many, many decades and they shift from one drug to the other.

There have been at least five heroin crises that I can think of off the top of my head. There have been methamphetamine crises prior to the current one. There certainly has been an opioid crisis as one of the

classifications of drugs. So, many, many drugs involved.

Q. Okay. So, my understanding from your report is that whenever that opioid crisis shift -- whatever time frame it lasted, your primary criticism of the plaintiffs is one that we are asserting a single causal argument. Do you recognize that terminology?

A. Now, are you referring to my report? Because I'm not here to offer any opinions about causation.

Q. Yes, ma'am. I understand. In your report, you do, though, do you not?

A. In my report, I talk about that, but that's not what I'm here today to discuss.

Q. Yes, ma'am. So, I have a question to ask.

A. Yes, sir.

Q. Is it fair to say that you believe that oversupply is not the causal factor of the opioid epidemic?

MS. MCCLURE: Your Honor, I would just note that Ms. Colston has been clear about what she's offered here today to do and what she's not offered here today to do. So, I would just object on the basis of scope at this point.

THE COURT: Well, I'll let her answer that question, but --

MR. FARRELL: We won't go far afield with this, Judge.

THE COURT: I'm sorry?

MR. FARRELL: I said we will not go far afield with this subject.

THE COURT: Okay. If you can answer the question, do so.

THE WITNESS: Would you repeat the question? Sorry.

BY MR. FARRELL:

Q. Yes, ma'am. My understanding is that you take the position that oversupply of prescription opioids is not the causal factor of the opioid epidemic, but is only a causal factor?

A. That's correct.

MR. FARRELL: I have no further questions, Judge. Thank you.

THE COURT: Do you have any redirect, Ms. McClure?

MS. KEARSE: I have a couple of questions, Your Honor.

THE COURT: Oh, okay. Ms. Kearse.

CROSS EXAMINATION

BY MS. KEARSE:

Q. Good afternoon, Dr. Colston. Just a couple of questions I want to follow up with on what you testified about today and specifically to follow up on Mr. Farrell, some of his questions there, too, but you obviously mentioned you read documents about Cabell County, City of

Huntington, and you read testimony, as well, correct?
A. I've read hundreds of pieces of information about Cabell County.
Q. Okay. So, you're well aware that at least the testimony has revealed over a thousand Cabell County residents have died from an opioid-related overdose?
A. During what period of time?
Q. From 2001 to 2018? Are you aware of that testimony?
A. I -- I believe that -- is that Mr. Hunter? I'm not real sure.
Q. Dr. Smith?
A. I beg your pardon?
Q. Dr. Smith? Never heard of him? Okay. Dr. Smith?
A. I'm aware of that statistic.
Q. And you've read about the thousands of overdose calls that the City and County employees have answered?
A. Yes.
Q. Okay. And you've read and heard testimony about the thousands of deployments of naloxone that has been administered in Cabell County; is that correct?
A. Yes.
Q. And naloxone, as the Court has heard, is a treatment for someone that overdoses from opioids; is that correct?
A. Yes.
Q. Okay. And naloxone is still present between the Fire

Department, the Health Department, the schools and the police all are equipped with naloxone?

A. Well, I believe -- I believe that's accurate. I don't recall the details, but I also know that the Cabell County -- Huntington Health Department restricted access to syringe services. So, there's -- there's been some restriction of the availability, but I'm not -- I'm sorry. I don't remember if that's naloxone.

Q. And that --

MS. MCCLURE: Your Honor, again, if we can let the witness finish.

THE WITNESS: Okay.

THE COURT: Yeah. Let her finish her answer.

MS. MCCLURE: Thank you.

BY MS. KEARSE:

Q. Do you know specifics about why there was a restriction?

A. Yes. I believe I do.

Q. Because -- okay. Restricted to Cabell County residents; is that fair?

A. Yes.

Q. Okay. And you --

A. I'm sorry. Would you tell me who you are? You didn't introduce yourself.

Q. Okay. I'm sorry. I'm Anne Kearse. I'm one of the

attorneys here that represents the City of Huntington. I apologize for that.

A. That's okay.

Q. We have not previously met.

Okay. And a couple other questions on the funds in regards to the opioid crisis and I want to be clear on a couple of things. The opioid crisis as it exists today, to the extent it exists, does it still have an impact on the community and City of Huntington and Cabell County?

A. Well, it depends on how you define the opioid crisis, number one. I believe we probably have a different way of defining it. It is an illicit fentanyl crisis and it is a methamphetamine crisis and, sometimes, they are used together and cause overdoses. So, that premise, I probably disagree with.

Q. Okay. Well, let me ask you this, Doctor. You mentioned Dr. Mullins, who is the Commissioner of Bureau of Health; is that correct?

A. Uh-huh.

Q. Did you read her deposition that was given in this case?

A. Yes.

Q. Okay. It's listed among your reliance materials; is that correct?

A. Yes. I think so.

Q. And do you know Dr. Mullins' testimony was taken after some of the things you just discussed today about what you relied on in regards to Dr. Mullins? It was taken --

A. Probably. It probably was.

Q. Okay. Well, do you have any reason to disagree that Dr. Mullins testified that the -- there was a lot to still do in regards to the opioid crisis in Cabell County and City of Huntington?

THE COURT: Ms. Hardin?

MS. HARDIN: Objection, Your Honor. She cannot use this witness to get Ms. Mullins' testimony into the record, particularly when there were such vociferous objections to us using a letter that Ms. Mullins had signed. So, we object to this line of questioning.

MS. KEARSE: I'm just asking her if she recalls as to the testimony --

MS. MCCLURE: Your Honor, I join that objection, especially in light of the fact that we were prevented from doing the same.

THE COURT: Just a minute.

I'm going to sustain the objection, Ms. Kearse.

BY MS. KEARSE:

Q. Doctor, in regards to the grants and funding that is available to various cities and counties in regards to -- to the opioid addiction and other substance use addictions, is

there any guarantee that the state and federal governments will provide additional funding in the future?

A. Well, they certainly have increased funding for several years and, if you look at President Biden's 2022 budget, he increases it by over a billion dollars. So, I have no reason to doubt that that funding very well may continue.

Q. Do you recall your testimony in this case, and I can show it to you if you want to, that you had no clue of the future, what the future holds?

A. Correct. Correct. I remember that.

MS. KEARSE: Okay. No further questions.

THE WITNESS: Okay.

MS. MCCLURE: Your Honor, a moment.

(Pause)

REDIRECT EXAMINATION

BY MS. MCCLURE:

Q. Ms. Colston, very briefly, picking up on a line of questioning you were just asked. As -- as an overall trend, is it your opinion that the federal government is making it easier for people with OUD to receive services, programs and medication for SUD and OUD?

MR. ACKERMAN: Objection to the leading, Your Honor.

THE COURT: Well --

MS. MCCLURE: Your Honor, I'll rephrase.

BY MS. MCCLURE:

Q. Ms. Colston, do you have an opinion as to whether the federal government is making any changes that address and affect the ability of individuals with OUD and SUD to receive treatment funding and services?

A. Yes. The federal government -- the federal government funding has substantially increased access to services with its hundreds of millions of dollars of funding.

Q. And is it your opinion based on your expertise and years of work in this field that that trajectory is likely to continue in the future?

A. Yes.

Q. And what do you base that opinion on?

A. I base that opinion on the increase in state opioid response grant money, the increase in substance abuse prevention and treatment grant money, and the fact that the President of the United States just introduced a budget that has an additional substantial increase in funding.

Q. And is that opinion also informed by West Virginia's grant of the 1115 waiver for Medicaid?

A. Yes, it is. Yes, it is.

Q. Ms. Colston, are the opinions you've offered here today to a reasonable degree of professional certainty?

A. Yes, they are.

MS. MCCLURE: I have no further questions, Your

Honor.

THE COURT: Anything else, Mr. Farrell or Ms. Kearse?

MR. FARRELL: No, Your Honor.

THE COURT: You can step down, ma'am, and thank you very much. You're free to go.

THE WITNESS: Thank you.

THE COURT: Thank you, Ms. Colston.

THE WITNESS: Thank you, sir.

MR. HESTER: Good afternoon, Your Honor.

THE COURT: Good afternoon, Mr. Hester.

MR. HESTER: The defense has no further witnesses to call, but we do have a few housekeeping matters before we close our record.

The first is that we have three settlement agreements that we wanted to move into evidence. These are settlement agreements between each of the defendants and the State of West Virginia.

We also want to move into evidence three final judgments in relation to those matters that underlie the -- or relate to the settlement agreements. And we've raised this with the plaintiffs and they have no objection.

The three settlement agreements are DEF-WV-2150, DEF-WV-2151, DEF-WV-2152. And the three final judgments are DEF-WV-3854, DEF-WV-3855 and DEF-WV-3856.

THE COURT: What's the relevance of these, Mr. Hester?

MR. HESTER: Your Honor, as the Court will recall before trial, we had moved for summary judgment on the basis of res judicata based on these settlement agreements and we understand there's a rule in the Fourth Circuit that summary judgment rulings are not preserved for appeal unless there's evidence presented in the record in relation to those motions. So, we're simply preserving our record on these points, Your Honor.

THE COURT: Well, you sure did answer my question, Mr. Hester.

MR. HESTER: Well, it -- we understand the Court's ruling, but we wanted to preserve our record on this.

THE COURT: And I understand there's no objection to any of that?

MR. MAJESTRO: Yes, Your Honor. We don't object to the authenticity of those documents for the reasons we've stated in our briefing in response to summary judgment motions. We don't -- the underlying basis that they're being offered doesn't -- isn't applicable in this case and -- without re-stating all of those arguments, but we don't have any objection to inputting those into the evidentiary record subject to our objections on the relevance.

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes, you may.

MR. HESTER: And then, Your Honor, in addition, we have filed a memorandum with the Court today. It's a trial memorandum in relation to judicial admissions that are found in the plaintiffs' complaints. And so, we want to move orally for the admission into the record of the judicial admissions that are covered by this trial memorandum, which we have filed within the past hour with the Court.

THE COURT: Is there any objection to this?

MR. FARRELL: Yes, Your Honor, there is. I'm sure there's a whole bunch of reasons, but the main thing is, is that they could file a motion for summary judgment. They could have filed 12(b)(6). The complaint is in the record, but I'm not quite sure that this is the proper vehicle to begin putting in judicial admissions by parties at the end of the day.

THE COURT: Well, shouldn't I read the document and then decide whether to admit it or not, Mr. Farrell? I mean, I'm kind of in the dark here.

MR. FARRELL: Yeah. Judge, I would recommend that you read it first and then make a decision afterwards and perhaps allow us to file a responsive brief.

MR. ACKERMAN: To piggyback on Mr. Farrell, not only should you read it, I would like the opportunity to read it, as well, and respond on behalf of my client.

THE COURT: Well, you can read it and file anything you want to in response and I'll read whatever you give me and make a decision.

MR. HESTER: And simply to explain it, Your Honor, just so that -- so that you understand at least why we're doing this, our view is that these are judicial admissions. They're admissions from the plaintiffs' complaint in this matter, but we understood that, as a matter of evidence, they need to be in the record and this is why we're submitting them and moving for their admission before the close of our evidence.

THE COURT: All right.

MR. HESTER: So, if I may approach, Your Honor?

THE COURT: Yes.

MR. FARRELL: Judge, I would simply make -- or for the record -- that the complaint that we filed are allegations and that it's not a verified complaint in federal court. So, I'm still -- I've been practicing 20-some years and I've never experienced this. So, I will withhold judgment until we get the chance to file responses.

THE COURT: Well, I'm going to reserve my ruling on this until I read the paper.

MR. HESTER: Thank you, Your Honor.

THE COURT: And whatever is offered in response.

MR. HESTER: And I think we have some deposition

designations to address. Thank you, Your Honor.

MS. MAINIGI: Good afternoon, Your Honor.

THE COURT: Good afternoon, Ms. Mainigi.

MS. MAINIGI: I think we have several deposition designations that the parties are still working through, in addition to the issues that Mr. Hester raised.

So, June Howard is ready to pass up. And then there are five other deposition designations that we're still in the process of working through. So, if we can keep the record open until those get completed, that would be quite helpful, Your Honor, since we are ending a little earlier than expected.

Those five, for the purpose of the record, are Darren Cox, Robert Knittle, Michael Mapes, the Cabell County 30(b)(6) witness and Gilberto Quintero.

MR. FARRELL: Judge, can I -- we would like to have an opportunity to respond. These witnesses aren't unavailable. And so, I'm not quite sure of the propriety of just putting into the record depositions, but to that extent, we'll work with counsel on it.

THE COURT: Well, I thought you had agreed that -- to do this. Are these --

MS. MAINIGI: I think we're going back and forth, Your Honor, on the actual designations, but these are witnesses, to our knowledge, that are unavailable.

Mr. Mapes, for example, is formerly with the DEA. Mr. Quintero is a former Cardinal employee that is no longer under our control. June Howard is DEA.

And with respect to the others --

MR. WICHT: The others are -- they're outside the subpoena power of this Court, Your Honor. Their depositions were taken in discovery outside of the subpoena power.

THE COURT: And they're unavailable, right?

MR. FARRELL: Judge, Beth Thompson lives 40 miles to the west of here. That's within the jurisdiction of the court. She lives in Huntington, West Virginia.

MS. WICHT: She was deposed, Your Honor, as a 30(b)(6) witness for Cabell County and that's what we're introducing, which is a statement of a party opponent.

MR. FARRELL: Your Honor --

MR. WICHT: Or against the party.

MR. IRPINO: Anthony Irpino on behalf of Cabell County. We are in the process of working through these with the defendants. The five listed outside of Ms. Howard are the ones that we are working through.

Three of those, including Beth Thompson, we received notice of yesterday. The normal process takes over a week. We usually get them on Mondays; then we respond by Wednesday; then they respond by Friday and we go through a process.

So, three of them, we're still in the early stage of, one of which Mr. Farrell referenced. The other two were at the end of that process and should be ready for submission shortly.

THE COURT: Well, work it out if you can and, if you can't, then you're going to have to find a way to submit the issue to me with enough -- what I need to know about whether they're available or not and so forth so I can make a ruling.

MS. MAINIGI: Yes, Your Honor. We can certainly do that. And I think subject to -- subject to these deposition designations and the issues raised by Mr. Hester, Your Honor, certainly on behalf of Cardinal, we rest.

THE COURT: All right.

MR. HESTER: Yes. And the same on behalf of McKesson, Your Honor. We rest subject to resolving these remaining issues on the depositions.

THE COURT: Mr. Nicholas?

MR. NICHOLAS: As do we on behalf of AmerisourceBergen.

THE COURT: All right. So, subject to these few loose ends, we're done with the evidence; is that right?

MR. FARRELL: Judge, for rebuttal, we would like to call -- no, I'm --

(Laughter)

THE COURT: That was my next question, Mr. Farrell, whether you had any rebuttal or not?

MR. FARRELL: We do not, Judge.

THE COURT: Okay.

MR. HESTER: Yes, Your Honor.

MS. MAINIGI: That's correct, Your Honor.

THE COURT: Does that take care of everything?

MR. HESTER: Takes care of the evidence, Your Honor. Thank you.

THE COURT: Except for closing arguments and set aside and allotted, what, six hours a side?

MS. MAINIGI: Yes, Your Honor.

THE COURT: Is that what we did? In a foolish moment, did I do that?

MS. MAINIGI: A weak moment, Your Honor.

THE COURT: And I am looking forward to hearing the arguments and I'll probably have a few questions as we go along, but I'm more interested in your interpretation of the evidence. But I'll reserve the right to ask some questions as we go along, if I feel the need to do that.

Anything else before we adjourn until the closing arguments?

MR. MAJESTRO: Your Honor, I -- on behalf of the plaintiff, we would like to thank the Court and the court staff for all the patience they've shown us over these

weeks.

MS. MAINIGI: We absolutely concur, Your Honor. I think there's been an incredible amount of patience and goodwill that has been displayed by all of the court staff and we're quite grateful.

MR. HESTER: And, Your Honor, we appreciate all the courtesy that the Court has shown to all the parties and all of the court staff. It's been -- it's been a pleasure to be appearing before you.

THE COURT: Mr. Nicholas, you have to say something, too.

MR. NICHOLAS: I guess I do. It's pretty impressive. It's been a really long trial and it's been pretty amazing. So, thank you very much.

THE COURT: Well, I appreciate that and I have my law clerks and my courtroom deputy to thank for keeping me under control.

And I will say this. I have had a lot of good lawyers in my court in 30 years on my bench, but I don't think I've ever had this many in one case at the same time and I -- I appreciate the work that all of you have done and I look forward to the arguments. See you then.

SIMULTANEOUS SPEAKERS: Thank you, Your Honor.

(Trial recessed at 2:44 p.m.)

CERTIFICATION:

I, Ayme A. Cochran, Official Court Reporter, and I, Lisa A. Cook, Official Court Reporter, certify that the foregoing is a correct transcript from the record of proceedings in the matter of The City of Huntington, et al., Plaintiffs vs. AmerisourceBergen Drug Corporation, et al., Defendants, Civil Action No. 3:17-cv-01362 and Civil Action No. 3:17-cv-01665, as reported on July 12, 2021.

S\Ayme A. Cochran
Reporter

s\Lisa A. Cook
Reporter

July 12, 2021
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